Elizabeth R. Brown MAPC, LMHC

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Elisabeth R. Brown MAPC, LMHC, to give/obtain information to/from:

_____

_____

_____

_____

Information to be disclosed:

____ medical, psychiatric, social

____ discharge information

____ other: _____

This consent will expire one year from the date of signature unless retracted in writing prior to that date.

Date _____ Signature of Client _____

Date _____ Signature of Witness _____

Please sent records to:

Elisabeth R. Brown MAPC, LMHC

Phone: 585-678-1618

Fax: 585-377-2779