Release of Information

This authorization allows me to share information about your sessions/treatment with someone you designate (e.g. your doctor or therapist). Please note that you will also need to fill out a release form of theirs for them to share information with me.

I, (Name of Client) _____ (hereafter "Client") hereby authorize Phoenix Mandel, CSE (hereafter "Provider") to disclose session and/or treatment information of the Client to:

Name(s):

_____

_____

_____

Phone Number(s):

_____

_____

_____

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of this authorization must be received in writing by Provider at: phoenix.mandel@gmail.com to be effective. I understand, further, that I have the right to revoke this authorization at any time, in writing, unless Provider has already taken action in reliance upon it. Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client Name: _____

Client Signature: _____

This authorization shall remain valid until (date): _____