AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, (Client's Name) _____, hereby authorize and request that

Maren Handler Siegel, LICSW
3000 Connecticut Ave, NW
Suite 237D
Washington, DC 20008
(202) 232-9100

Release and exchange all confidential medical, psychological, psychiatric, educational and/or other appropriate information acquired in the course of treatment (or those of minor children) to and from:

Name of Information Source:

Address and Phone #:

I understand that I can revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Client Signature:

_____Date_____

And/or

Parent/Guardian Signature:

_____Date_____