Susan E. Kotulsky, LMFT, LLC
Fairfield, CT 06824

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ________________________________, hereby authorize Susan E. Kotulsky, LMFT, License #001469, to disclose information and records obtained in the course of my diagnosis and/or treatment to:

____
Name/Entity to whom disclosure is made

____
Address

____
Phone Fax

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This disclosure of information and records authorized herein is required for the following purpose:

assessment and diagnosis　　medication evaluation　　medical compliance

recommendations　　treatment coordination　　referral

The specific uses and limitations on the types of medical information to be disclosed are as follows:

medications　　assessment and diagnosis　　testing results

treatment recommendations and progress　　coordination of treatment

This authorization shall remain valid until: ______________________________.

Client Signature: __________________________________ Date:________.

Client Signature if patient is a minor: __________________________________.