Self in Context Psychotherapy

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Authorization to Obtain and Release Information

I, ____, the undersigned, give permission to Dr. Siri Hoogen, PhD to release and provide to and/or request from:

____
(Name)

____
(Address)

____
(Phone Number)

the following information (check all that apply)

- ☐ my attendance in therapy
- ☐ my diagnosis
- ☐ my treatment plan
- ☐ information relevant to coordination of care
- ☐ other (please describe in detail) ____

____

I understand that this release is valid for a period of 120 days. I further understand that I may revoke this authorization at any time in writing.

In consideration of this request, I hereby release the above parties from any legal liability resulting from the release of this information.

____ ________________________
Signature Date