GRANOFF THERAPY & CHAGRIN BRAIN TRAINING CENTER

DAVID GRANOFF, PSY.D
Licensed Clinical Psychologist

Authorization to Release Health Care Information

Client Name _____ Date of Birth _____

Please release (and/or receive) health care information to (and/or from):

Name and Organization _____

Address_____

Phone Number(s)_____

E-Mail Address_____

_____ _____
Client or legally authorized signature Date

This authorization terminates upon termination of treatment. If client or parents (in the case of a minor) would like to terminate this permission at an earlier date, they may do so at any time by either signing below or sending a hardcopy letter with signature and date.

REVOCATION

_____ _____
Client or legally authorized signature Date