CORA GOLDFARB
PSYCHOTHERAPY & PSYCHOANALYSIS

Consent for the Release of Confidential Information

I, _____, born on _____
Patient *Month/Date/Year*

And currently living at _____

Authorize Cora Goldfarb, LCAT, LP to disclose and receive information

To/From _____

Who can be contacted at _____.
Phone number

I, the undersigned, understand that the information to be released from my record is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released.

_____
Signature of Patient

_____
Signature of Therapist