

Susan J. Levy, M.Ed.
Psychotherapist

1151 Sheridan Rd. N.E., Atlanta, GA 30324 ▪ Phone: 404-325-1747 Fax: 404-325-0789

Consent for Release of Confidential Information

I, _____ hereby authorize and request that
(print name)

Susan J. Levy, M.Ed., LMFT,

may release confidential professional information pertaining to me (or my minor children)
to:

for the purpose of:

I understand that I may 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 and legal liability for the release of this information.

Signature: _____ Date: _____
(client)

and/or

Signature: _____ Date: _____
(parent or guardian)