Print Form

# Aristotle's Psychological and Biofeedback Services

**31-09 37th Street**
**Astoria, NY 11103**
**Phone: (718) 721-4300 www.AristotlesPsychological.com Fax: (718) 721-5600**

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I, _____, give full authorization to _____ to furnish information regarding my mental health information to:**

**Name** _____

**Address** _____

**City, State, Zip** _____

**for the purpose of _____. This consent is subject to revocation by the undersigned, and remains in force for 45 days from the date of signature. By signing and dating this release of information, I allow the person listed below to share specific record information.**

**Name** _____

**Address** _____

**City, State, Zip** _____

_____

**Client's Signature**

_____

**Mental Health Representative**

_____

**Date**