

**Meredith Kornfeld, MS, MFT**

**Authorization Consenting To Release Of Information**

I \_\_\_\_\_ authorize Meredith Kornfeld to:

release to:

obtain from:

exchange with:

\_\_\_\_\_  
\_\_\_\_\_

the following information pertaining to myself:

treatment summary

history/intake

diagnosis

psychological test results

dates of treatment attendance

other (specify) \_\_\_\_\_

for the purpose of:

evaluation/assessment and/or coordinating treatment efforts

payment

other (specify) \_\_\_\_\_

**This consent will automatically expire three (3) years after the date of my signature as it appears below, unless I renew the authorization.**

**I understand I may revoke my consent at any time (except to the extent that the information has already been released).**

\_\_\_\_\_  
Client Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date