CONSENT TO RELEASE

I, ______________________, give my consent to release information pertaining to my psychological treatment with Dr. Susie Mendelsohn (dba Fort Lauderdale Psychology Group) to the following individuals. (Treatment includes but is not limited to: group and individual therapies, testing, effects of medications, cognitions, behaviors, attitudes and emotions pertaining to therapeutic interventions.)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

This has been discussed and explained to me by Dr. Susie Mendelsohn and I give my consent to release any information pertinent to my treatment.

____
Printed Name of Patient or Patient’s Guardian

____
Signature of Patient or Patient’s Guardian

____
Date Signed

____
Clinician’s Signature