CLARKSTON FAMILY THERAPISTS
5639 Sashabaw Road
Clarkston, MI 48346

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I hereby authorize Clarkston Family Therapists to notify my medical doctor of my receiving treatment here, diagnosis, and to inform him/her of any pertinent information.

My medical doctor's name and address are as follows:

_____
Doctor's Name

_____
Street Address

_____
City, State and Zip Code

I realize that a copy of the form letter that may be sent to my physician is available to me upon request. I can rescind this authorization at any time. This authorization will automatically terminate six months after my treatment ends.

_____
Patient (Child's) Name Please print

_____
Signature of Patient or Parent/Guardian Date

8/17