Consent to Release Information

I, _____ ("Patient"), hereby consent to release information regarding my therapy with Marsh Tilles, PsyD, LCSW, to the following individual(s):

1. _____
2. _____
3. _____

I do not consent to release the following information (if applicable):

This authorization shall expire at 11:59 PM on: _____

Expiration Date
(not to exceed 12 months)

I understand that, upon written notice, I may withdraw my consent at any time.

_____ _____

Signature of Patient **Today's Date**
(Patient's Parent/Legal Guardian if under 18)

Marsha Tilles, PsyD, LCSW / Lic.# LCS24181 / 310.746-5366 / www.DrMarshaTilles.com