NEWTOWN THERAPY
& WELLNESS CENTER

RELEASE OF INFORMATION

I _____ , hereby authorize Newtown Therapy to release and exchange information pertaining to my evaluation and therapy sessions to:

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter. I have been informed that I may revoke this authorization by written or email communication to Newtown Therapy. I certify that this form has been fully explained to me and that I understand the content.

_____ _____

SIGNATURE DATE OF AUTHORIZATION