RELATIONSHIP & SEX THERAPY ASSOCIATES
401 S. 2ND St. Philadelphia, PA 19147

Phone: 302-521-0659 dr.wood@philatherapy.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, give full authorization to ____________________ to furnish information regarding my mental health to:

Name: ____

Phone: ____

Address: ____

City, State, Zip: ____________________________________

for the purpose of ____________________________________. This consent is subject to revocation by the undersigned, and remains in force for 48 days from the date of signature. By signing and dating this release of information, I allow the person listed below to share specific record information.

Thomas N. Wood LCSW, PhD
401 S. 2nd St., Suite 401
Philadelphia, PA 19147

____
Client's Signature

____
Mental Health Representative

____
Date