**CONSENT FOR RELEASE OF INFORMATION**

**THE HARBOR PSYCHOTHERAPY SERVICES, LCSW, PLLC**

1600 Harrison Avenue, Suite G104-5

Mamaroneck, NY 10543

O (914) 907-0443

F (914) 637-3602

I authorize The Harbor Psychotherapy Services, LCSW, PLLC, to request information pertaining

to my medical records with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the interest of providing

psychiatric treatment.

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Signature of Client/Guardian if client is under 18 Date

I authorize The Harbor Psychotherapy Services, LCSW, PLLC, to release information pertaining

to my medical records with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the interest of providing

psychiatric treatment.

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Signature of Client/Guardian if client is under 18 Date

This consent will expire 1 year from the date it has been designated. The client may withdraw consent at any time. To do this, the client will need to write a letter to Jennifer Nikou, PhD., LCSW-R, requesting that permission has been withdrawn. The letter should include the date by which consent is no longer valid. I, the client, understand that withdrawing consent is not plausible once the information has been disclosed by The Harbor Psychotherapy Services, LCSW, PLLC.