Dawn M. Roy, LCSW
540 Tunxis Hill Road
Fairfield, CT 06825

Authorization to Release or Receive Information

I, _____, hereby
(Print name)

authorize my therapist, Dawn Roy, LCSW, to release to and/or receive from:

_____

_____

verbal and written information about my case for the purpose of :

_____

_____.

I understand that I may withdraw this authorization at any time by providing written notice to my therapist, though any information already released will continue to be covered under the original authorization. Unless withdrawn earlier, this consent shall expire on _____.

By signing below, I affirm that I have read this Authorization, that I understand my rights to confidentiality in counseling, and that this Authorization represents an express waiver of such rights for the purpose set forth herein.

_____
(Signed)

_____
(Date)

203-331-7458
ladyroy@earthlink.net