

Merle Saber
Licensed Marriage & Family Therapist
161 W. 25th Avenue, Suite 101
San Mateo, CA 94402

Authorization Consenting to Release Information

I authorize **Merle Saber** to **discuss** (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff or clinic, office, agency, or institution/s named below and receive any relevant information **from** them.

1. _____
2. _____
3. _____
4. _____
5. _____

For the following reason(s):

_____ Consultation/Psychotherapy,
_____ Evaluation,
_____ Other: _____

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Patient-Psychotherapist Service Agreement.

Name (print)	Date	Signature
Name (print)	Date	Signature