Selman Behavior Solutions

Finding Solutions • Creating Change

www.SBSolutionsNY.com

Consent for Release of Information

I, _____, authorize Selman Behavior Solutions, to discuss my information and/or treatment with the following:

Name/Affiliation _____

Address_____ City_____

State_____ Zip_____

Phone Number _____ Fax Number _____

Email Address _____

This authorization will remain in effect until _____ If no expiration date is indicated, consent will expire one year from the date it is signed.

I understand that I have the right to revoke this authorization at any time by sending written notification to Selman Behavior Solutions at the above address.

By signing below, I authorize Selman Behavior Solutions to release information regarding the above patient's treatment to named party.

Patient Signature_____ Date_____