MIDTOWN
PSYCHOTHERAPY
ASSOCIATES, PLLC

Mental Health Professionals

Release of Information & Consent Form

It is important that health care providers work together. As such, I, **Midtown Psychotherapy Associates, PLLC**, would like your permission to communicate with ____________________________.

Client Name:	**DOB:**
SSN:	**Phone:**
Address:	**City, State, Zip:**

I, ____, hereby authorize the release and exchange of information specified below between:

Name/Title or Organization Name

Organization/Address

Phone/Fax

and

Midtown Psychotherapy Associates, PLLC
701 Richmond Ave., Suite 110
Houston, TX 77006
P: 713-689-8252

This release of information shall be limited to the following specific types of information:

Client Name (Printed)

Client Signature Date