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## **Authorization for Release of Information**

l,		, hereby authorize
(Print na	ime)	
Toni Rabinowitz, Ph.D, LMFT to excha	nge information about me with	ո:
(Name of pe	erson and organization)	
	(Address)	
(Tele	ephone number)	
This information may be exchanged by	mail, fax, telephone, and face	e-to-face meetings.
Please state any restrictions or clarific or initial "None": None	cations on information authoriz	zed to be released
Purpose to be served by released infor	rmation:	
I understand that this release will be in extended or revoked in writing.	n effect for one year from the	date signed, unless
Client signature	Client birth date	Date signed
Witness Signature	 Date Witnessed	