MICHELE SAFFIER

& ASSOCIATES

Licensed Marriage & Family Therapist • Certified Sex Addiction Therapist • EMDR Level III Trained Practitioner

Authorization for Release of Healthcare Information

Date: ________ / ________ / ________

I _________________________ Permit _________________________ to obtain and/or release

my: ____ Progress ____ Evaluation
____ Treatment Summary ____ Other (Specify) ____________________________

From and/or to ____

Phone Number: ____

Address: ____

For the purpose of: ____

To be restricted to: ____

To terminate on: ____

By signing below, I state my understanding that I may revoke this authorization at any time except after the above material has already been obtained or released pursuant to my prior authorization.

This authorization will expire one year from the above date, unless specifically stated to the contrary.

Patient/Guardian____Date_______________

Witness____

17 Barclay Street, Building A, Newtown, PA 18940
1717 Swede Road, Suite 104, Blue Bell, PA 19422
215-552-8938 MSaffier@traumahealingpa.com www.traumahealingpa.com