Charles M. Iker,
LCSW, ACSW, BCD

C M I
PSYCHOTHERAPY

160 Allens Creek Road
Rochester, NY 14618-3309
(585) 461-4810

CONSENT TO DISCLOSE INFORMATION

PATIENT'S NAME _____ BIRTH DATE _____

This is to give permission to Charles Iker, LCSW, to release or obtain information about me as outlined below.

EXTENT AND NATURE OF INFORMATION TO BE DISCLOSED: _____

_____

_____

_____

NAME OF PERSON TO WHOM THE DISCLOSURE IS TO BE MADE:

Charles M. Iker, LCSW, BCD
160 Allens Creek
Rochester, New York 14618
585.461.4810

NAME OF PERSON/ORGANIZATION FROM WHICH THE DISCLOSURE IS TO BE MADE:

_____ _____
(Name of Person/Organization) (Address)

_____
(City and Zip Code)

I, the undersigned, have read the above and authorized the staff of the disclosing facility to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.

Disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

_____ _____
(Signature of Patient or Parent/Guardian if patient is a minor) (Signature of Witness)

_____
(Date)