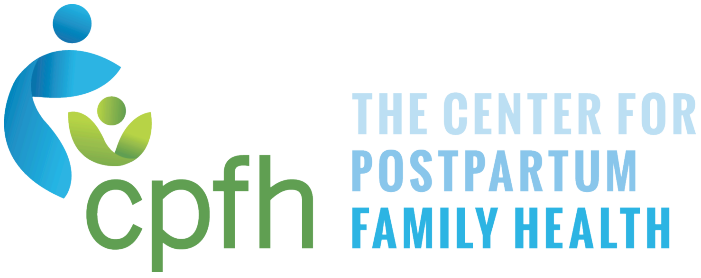

AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

I, _____, hereby authorize my clinical care team at The Center for Postpartum Family Health, to release confidential information regarding my psychotherapy treatment. With my signature I verify that she has my permission to release details of dates of service and nature of services rendered, as well as opinion regarding the nature of my condition and progress made.

_____ _____
(Signature) (Date)

_____ _____
(Address) (City, State, Zip)

_____
(Telephone)

Released to the following:

Name of person or agency permission is granted to share information with:

_____
(Name)

_____ _____
(Address) (City, State, Zip)

_____ _____
(Telephone) (FAX)

Please sign and return to:
The Center for Postpartum Family Health
3418 Mercer, Suite 1000
Houston, Texas 77027
Email: info@cpfh.org
FAX: 713. 961.0797