Anxiety Treatment Center of Greenwich
Jill Vaughan Tesei, APRN
Maryellen Pachler Kennell, APRN

RELEASE OF INFORMATION

To: _____

Address: _____

_____

Telephone: _____

Fax: _____

I, _____ give permission for the Anxiety Treatment Center of Greenwich

to exchange information with _____ regarding my son/daughter/myself

in order to assist in treatment. This release is valid during the time period from _____

to _____.

Client Name (print): _____

Client Consent: _____
(13 and over)

Parental Signature: _____

Date: _____/_____/_____

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