Rena J. Goldin, PsyD, CGT
10 Minell Place
Suite 7
Teaneck, NJ 07666
201-725-7158
NJ License #5191

CONSENT FOR RELEASE OF INFORMATION

I, _____, give consent to Rena Goldin, PsyD,CGT
(Print Name)

to contact _____ to discuss:

__ all issues relevant to my treatment

__ specified information, as detailed below:

I understand my rights with regard to disclosure of information, and I am explicitly giving Rena Goldin, PsyD, CGT permission to share this information. I also understand that I can revoke this permission at any time once I have signed the Revocation Statement below.

CLIENT'S SIGNATURE: _____

DATE: _____

IF applicable:

PARTNER'S SIGNATURE: _____

DATE: _____

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CONSENT FOR RELEASE OF INFORMATION

Revocation of Permission for Consent:

I no longer give Rena Goldin, PsyD, CGT permission to be in contact with the above individual(s) regarding my treatment.

CLIENT'S SIGNATURE: _____

DATE: _____

IF applicable:

PARTNER'S SIGNATURE: _____

DATE: _____