Linda B. Domenitz, MA, LMFT, LPC
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45 So Main Street, Suite 307, West Hartford, 06107

RELEASE OF INFORMATION

Permission for the Coordination of Treatment

To provide me with well-rounded and appropriate care, and to comply with professional, legal and ethical guidelines for the coordination of my treatment, Linda B. Domenitz, MA, LMFT, LPC, requests that relevant information regarding my treatment under your care be shared with her in writing or by phone.

For the purpose of my ongoing treatment and planning, I give Linda B Domenitz, Marriage and Family Therapist, permission to both receive relevant information from you AND for her to provide relevant information regarding my treatment to you:

Professional's Name _____

Office Street Address _____

City, State and Zip _____

Phone number(s) _____

Best time to call _____

This release of information
expires 3 months after the date of termination of therapy or upon client's request.

Client signature _____ Date _____

Client (print full name) _____ Date _____

Guardian signature _____ *Date* _____

Gail Tomala's signature _____ Date _____

Coordinating professional's signature_____ Date_____

Note: Your signature indicates a mutual agreement with Linda B. Domenitz to both provide relevant information upon request or as deemed appropriate, and to receive updates from her regarding this client's therapy.