TO: _____

FOR: ___Your Files ___Please call me at 917--816-8882 _____

Joy A. Dryer, Ph.D.
Licensed Psychologist
Certified Psychoanalyst

PERMISSION TO RELEASE INFORMATION

I, _____ , give permission for the
PLEASE PRINT
following two professionals to discuss oral or written information about me that is pertinent to my care.

_____*Joy A. Dryer, Ph.D.*__		AND	_____
CONTACT PHONE AND FAX:	____*917-816-8882*____ ____*718-643-1031* ____	CONTACT PHONE AND FAX:	_____ _____

I understand that this Permission allows information to be transmitted either to or from both of the above named. I also understand that this Permission is voluntary and I can revoke it in writing at any time.

_____ _____

Signature Today's Date

917-816-8882 cell ***www.therapyworksny.com*** ***718-643-1031 fax***

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