AUTHORIZATION TO EXCHANGE INFORMATION

Client Name: _____ DOB: _____

Client Name: _____ DOB: _____

I give permission for Jennifer Goldin, Ph.D. and the staff at _____ to exchange written and verbal information about my medical and psychotherapy treatment for the following purposes:

Notification of beginning and/or ending of treatment
Periodic summary of progress
Coordination of services/treatment planning
Educational information
Psychological evaluation/consultation
Other _____

I also give my permission for Jennifer Goldin, Ph.D to exchange written and verbal information with the following people:

_____ Relationship: _____

_____ Relationship: _____

This consent for release of information is given freely and may be revoked at any time.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date