AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, _____Address_____

Authorize: Sheila Bloom Singer, Psy.D.
1640 Town Center Circle, S-204
Weston, Florida, 33326
Phone: (954)349-1060 Fax: (954)380-5866

To Obtain:
( ) Treatment Summary
( ) Discharge Summary
( ) Psychological Evaluation/Testing
( ) Psychiatric Evaluation
( ) Medical History
( ) HIV and/or Drug/Alcohol Abuse/Addiction
( ) Information re: Emergency Treatment and AMA
( ) Treatment Plan and/or Progress
( ) Consultation
( ) Other: _____

From the following:

Name: _____
Address: _____
_____
Phone: _____

To Release:
( ) Psychological Evaluation
( ) Psychological Testing
( ) HIV and/or Drug/Alcohol Abuse/Addiction
( ) Information re: Emergency Treatment and AMA
( ) Treatment Plan and/or Progress
( ) Consultation
( ) Other: _____

To the Following:

Name: _____
Address: _____
_____
Phone: _____

I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein. Further, this release will remain in force throughout treatment.

Date: _____ Signature of Client: _____

Signature of Parent/Guardian: _____

Witness: _____

I hereby revoke my consent:

Date: _____ Signature of Client: _____

Signature of Parent/Guardian: _____

Witness: _____