# AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, ________________________________ Address ______________________________________________________

Authorize: Steven Reisler, Psy.D., PA
5300 W. Atlantic Ave., Suite 408
Delray Beach, FL 33484
Phone: (561) 239-4062

To Obtain:
- (X) Treatment Summary
- ( ) Discharge Summary
- (X) 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
- (X) Consultation
- ( ) Other: ______________________________________________________

From the following:

Name: ______________________________________________________
Address: ______________________________________________________
______________________________________________________
Phone: ______________________________________________________

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

To the Following:

Name: ______________________________________________________
Address: ______________________________________________________
______________________________________________________
Phone: ______________________________________________________

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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. A copy of this authorization is as valid as an original.

Date: ____________ Signature of Client: ______________________________________________

Signature of Parent/Guardian: ______________________________________________

Witness: ______________________________________________

I hereby revoke my consent:

Date: ____________ Signature of Client: ______________________________________________

Signature of Parent/Guardian: ______________________________________________

Witness: ______________________________________________