I, _________________________, hereby consent to, direct and authorize Dr. Stephen Ginsberg to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/ treatment. Authorization is thus granted to Dr. Stephen Ginsberg and/or to the following person or agency:

____

Name of Person or Agency

____

Address, City, State, Zip Telephone Number

The following, what I would like released or disclosed, includes:

___ Psychological Reports

___ Therapy Progress Notes

___ Diagnoses

___ Medical History & Medication Information

___ Billing Related Information

___ Tests Taken and Testing Scores

___ Other (Specify):______________________________________

___ Any and All Records/Information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Stephen Ginsberg and his staff from any and all liability arising from release and disclosure of the information and records to the above named person or agency.

____

Client Name (Printed) Signature Date

____

Witness Name (Printed) Signature Date

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