GINSBERG
PSYCHOLOGY

I, _____, hereby consent to, direct and authorize Dr. Amy Ginsberg to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/ treatment. Authorization is thus granted to Dr. Amy 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. Amy Ginsberg and her 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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