Raurie Birch, M.A., Psy.D.

49 8th Avenue, Brooklyn, NY 11215

CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

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

Address: _____ Phone Number: _____

The information or records to be released or disclosed include:

_____ Initial Evaluation/History

_____ Psychiatric/Psychological Reports

_____ Medical Information

_____ Therapy Notes

_____ Billing Records

_____ Transfer/Termination Summary

_____ 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. Raurie Birch and her staff from any and all liability arising from release and disclosure of the information and records to the above named person.

Signature of the Patient:

_____

Signature of Personal Representative:

_____

Relationship to Patient if Personal Representative:

_____

Date of signature:

_____