CONSENT FOR VOLUNTARY TREATMENT

I hereby consent to and authorize ___ Cheryl Gotthelf, Ph.D. or ___ Marsha Minkin, Psy.D. to provide treatment and therapy, which in their judgement, they consider necessary or advisable for my treatment and diagnosis.

I understand that this consent/authorization may be amended or revoked by me at any time upon notification.

MEDICAL/INSURANCE RELEASE

I authorize the release of any medical or other information necessary to process an insurance claim.

RECORDS RELEASE

Date:________________________

TO:____

I hereby authorize you to release to:

____

any information including diagnosis and records of any treatment or examination rendered to me.

______________________________________ ____________________

Consumer's Signature **Date**
(Patient or Guardian)

______________________________________ ____________________

Witness Date