Dr. Tzippora Jennifer Wallach, Psy.D.
Licensed Psychologist
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CONSENT FOR RELEASE OF INFORMATION

This authorization must be completed by the patient or patient's legal guardian to use/disclose protected health information in accordance with state and federal laws and regulations.

I give consent to Dr. Jennifer Wallach to speak with

_____(Name of Person)

_____(Phone Number)

_____(Relationship)

I hereby authorize Dr. Wallach and the person described above to disclose confidential information to facilitate my treatment. I understand that this consent for release of information is valid until I am no longer receiving services from Dr. Wallach or I inform Dr. Wallach in writing that I wish to revoke authorization.

_____
Patient's Date of Birth

_____
Printed Name of Patient

_____ _____
Signature of Patient or Guardian Date