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CONSENT FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of Patient: _____
Date of Birth:_____

I hereby authorize the release and exchange of information between my psychiatrist or consultant, Julia Eilenberg, M.D., and the following individual, agency, or institution:

Name:_____
Address:_____
Phone: _____ Fax: _____

Relationship to client:
_____

This authority extends to the furnishings of copies of all or any desired portion of the records, pertaining to the above-named client. This exchange is for the purpose of
_____
_____
_____
and expires (5) five years from the date signed unless otherwise specified.

The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this consent at any time by informing all of the above parties in writing. A photocopy or electronic copy is as valid as the original. This is a strictly confidential patient medical record. **Re-disclosure or transfer is expressly prohibited by law.**

Signature of Patient: _____
Date: _____
Witness: _____