

AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, _____ Address _____

Authorize: Steven Reisler, Psy.D., PA
7301 W. Palmetto Park Rd., Suite 205A
Boca Raton, FL 33433
Phone: (561) 239-4062

To Obtain: Treatment Summary
 Discharge Summary
 Psychological Evaluation/Testing
 Psychiatric Evaluation
 Medical History
 HIV and/or Drug/Alcohol Abuse/Addiction
 Information re: Emergency Treatment and AMA
 Treatment Plan and/or Progress
 Consultation
 Other: _____

From the following:

Name: _____
Address: _____
Phone: _____

To Release: Psychological Evaluation
 Psychological Testing
 HIV and/or Drug/Alcohol Abuse/Addiction
 Information re: Emergency Treatment and AMA
 Treatment Plan and/or Progress
 Consultation
 Other: _____

To the Following:

Name: _____
Address: _____
Phone: _____

I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein. Further, this release will remain in force throughout treatment. A copy of this authorization is as valid as an original.

Date: _____ Signature of Client: _____
Signature of Parent/Guardian: _____
Witness: _____

I hereby revoke my consent:

Date: _____ Signature of Client: _____
Signature of Parent/Guardian: _____
Witness: _____