ARIELLA SOFFER, PH.D. PLLC

CONSENT TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____authorize Ariella Soffer, Ph.D. to release/exchange information pertinent to myself/my child to:

_____

Name of Person or Institution

_____

Specific type of information to be disclosed/exchanged:

_____Assessment
_____Attendance
_____Treatment Progress
_____Other_____

_____Treatment Summary
_____Recommendations
_____Drug/Alcohol Issues

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records.

This release expires in 12 months unless another date is specified:_____

_____

Name *(Signature)* **Date**

_____

Name *(Print)*