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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name: _____

I authorize the exchange of information between the following mental health professionals, healthcare providers, agencies, medical facilities, educational institutions or staff, or legal representatives as specified below, for the purposes of coordinating services, patient care and treatment planning, or consultation.

I authorize **Ariati S. Rakic, Ph.D.** or her representative to release information to:

Name of Provider/Organization _____

Address: _____

Phone Number: _____

I authorize _____

to release information to **Ariati S. Rakic, Ph.D.** or her representative.

This authorization includes the release of all pertinent psychiatric, educational, medical, and/or legal information, and should be valid for a period of one year, unless otherwise specified.

Signature of Patient or Representative

Date