Laurie Leventhal - Belfer, Ph.D.

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Adult Authorization for Exchange of Confidential Information

Date: ____

Full Name: ____

Date of Birth: ____

I give my permission for ( ) an exchange of information and records between Laurie Leventhal – Belfer Ph.D., and (list names and addresses).

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( ) a release of records from Dr. Leventhal – Belfer to (list names and addresses).

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( ) a release of all medical, psychological, educational, and/or other pertinent records related to the individual to Dr. Leventhal – Belfer only.

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Thank you for your prompt response.
These releases are valid for one year from the above date.

____ _________________________

Signature **Date**

____

Printed Name