WENDI S. MAURER, Ph.D.
Clinical and Consulting Psychology

AUTHORIZATION FOR RELEASE OF CONFIDENTIALITY

I hereby authorize **Wendi S. Maurer, Ph.D.** and:

_____

to engage in mutual exchange of records and/or information pertaining to:

_____

I understand that the medical records and information to be released may contain information pertaining to psychiatric-related treatment, and may contain confidentially related information. I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This consent form is freely given and I have not been threatened with discontinuance or refusal of services if I do not sign this form.

LIMITATIONS TO THIS RELEASE ARE: (Initial one)
_____ I limit this release to these subjects:
_____
_____
_____
_____ I place no limits on this release.

I understand that the above named parties may FAX my Medical Records in order to help assure prompt treatment or continued care.

THIS RELEASE SHALL BE VALID: (Initial one)
_____ _____Specify Date.
_____ until I notify you otherwise in writing.

I understand that this authorization, except for action already taken using this authorization, may be revoked by me at anytime.

_____ _____
(Signature of Individual) (Date)

_____ _____
(Signature of person who is authorized to act on his/her behalf) (Date)

_____ _____
(Signature of Witness) (Date)

A PHOTOCOPY OF THIS ORIGINAL IS TO BE TREATED AS AN ORIGINAL.

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