**AUTHORIZATION TO RELEASE/RECEIVE INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Barbra Seltzer to receive/release information relevant to my care from/to physicians, therapists, educators, health insurance companies and other health professionals for diagnostic, treatment planning and billing purposes. I understand that I can revoke this authorization at any time in writing.

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_