Ira Orchin , Ph.D.

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AUTHORIZATION TO REQUEST/RELEASE INFORMATION

Client:_____

Date of Birth:_____ Telephone #_____

Address:_____

_____

I give permission to: __ Dr. _____ to release information to Dr. Orchin

__ Dr. Orchin to release information to Dr. _____

__ Dr. _____ and Dr. Orchin to exchange information

From my record, the information to be released should include:

_____ intake and assessment information

_____ treatment information

_____ other

The information is needed for:

_____ treatment planning and collaboration

_____ other

I understand that I may cancel this consent at any time by notifying Dr. Orchin in writing and that my cancellation will take effect on the date signed.

Signature of Client _____

Date _____