Consent for Release of Information

I, _____, voluntarily authorize the bilateral sharing and release of information regarding my medical and mental health care (including historical treatments and evaluations, as well as current functioning and concerns) between my psychologist Dr. Ivy Margulies and the contacts listed below. I realize that I can revoke my consent to allow communication between these individuals at any time, and will provide written documentation of this desire to Dr. Margulies at that time to notify her of my decision.

Primary Care Doctor:_____

Phone:_____

Psychiatrist:_____

Phone:_____

Closest Family Member:_____

Phone:_____

Specialty Provider (OB/GYN, Pediatrician, Attorney, etc.):

_____

Phone:_____

Other:_____

Phone:_____

If I only want to give permission for certain details be disclosed, I will list them here. Otherwise, full disclosure by both parties is permitted.

Signature:_____

Printed Name:_____

Date:_____

Phone:_____