Fulton Psychological Group

Adam Segal, Psy. D.
Licensed Psychologist PSY 32584

Authorization to Release Information

Patient: _____

Address:_____

I hereby authorize Adam Segal, Psy.D. to disclose and/or receive from

_____

(name) (phone #)

information pertaining to my (or my child's) psychological services rendered from:

_____ to _____.

Specific information requested includes: _____

_____

This authorization is good until: _____

This authorization allows Dr. Segal to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Dr. Segal's signature: _____ Date: _____