Miriam Wolosh Ph.D.
Psychologist
31 Dehart Avenue
Morristown, NJ 07960
973-540-9943
License #3381

AUTHORIZATION TO RELEASE INFORMATION

I, (_____________), (hereinafter "Client") hereby authorize Dr. Miriam Wolosh , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to:

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I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at her office address 66 Maple Avenue Morristown NJ to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:

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_______ ____

Such disclosure shall be limited to the following specific types of information: Please be as specific as you would like.

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Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: ______________________________________

Client's signature: ______________________________ Date:_________________