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

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of parent or guardian)** ______________________________, hereby authorize **Dr. Miriam Wolosh** (also referred to as "provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of ____________(**name of patient who is a minor**) including, but not limited to, therapist's diagnosis of child 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 **66 Maple Avenue Morristown NJ** to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:
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Such disclosure shall be limited to the following specific types of information:
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I understand that I have the right not to sign this form. In some cases however, communication with medical staff is an essential component of the treatment. Dr. Wolosh would then discuss with me the implications of not allowing communication with other professional or medical staff .

I understand 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.

This authorization shall remain valid until: ___________________________________

Patient's signature when applicable __________________________________

Parent or Guardian signature ____