Fishbein
& Associates
Performance Consulting

----

www.dr-fishbein.com

Authorization to Release Confidential Records/Information

Client: ____

Address: ____

Email: _________________________________ Work phone:__________________________

Cell phone: ____________________________Home phone:____________________________

I authorize **Fishbein & Associates Performance Consulting** to release records and/or information to and to receive records/information from the following individuals.

This authorization begins on _____________ (date) and ends:

□ in 12 months

□ at the termination of treatment

□ on ______________ (date).

	Name	Address	Phone
Physician			
Parents or Spouse			
Coach/Trainer			
Other Healthcare Professional			

□ Yes □ No I give permission for clinicians to discuss my case via email as long as initials, but not my name is used. I understand this request/authorization to release records and information. I understand that I can take back this consent in writing at any time. This consent will expire on the date I checked above.

Name of Client: _________________________________/____/_____________
(18 yrs. or older) Print Name Signature Date

Parent/Guardian: _______________________________/____/_____________
(if <18 yrs. old) Print Name Signature Date