Mindy Haber LCSW-R

Permission to Exchange Information

I _____________________________________hereby

authorize Mindy Haber LCSW-R to release and obtain information from the below named Provider/Person or Agency regarding my care including any medical records, psychiatric records, hospital records, school records or clinical information:

Provider/Agency____

Street Address:____

City/State/Zip Code:_______________________________________

Phone #:__________________________Fax#___________________

Signature:____

Print Name:____

Name of Person Signing if Patient is a Minor:____

This release is valid for 12 months from the date signed. This release can be revoked, via writing, by patient or guardian at any time.