Steven M. Blankman, Ph.D.
Clinical Psychologist
License No. PSY 6963

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Request/Authorization to Release Confidential Information

I hereby authorize: *(Person or facility)*_____
*(Address)*_____
(Phone) _____
to release information to Steven M. Blankman, Ph.D., concerning *(patient)*_____, born on _____, for the sole purposes of further psychological evaluation, treatment, c consultation. These records concern the time between_____ and _____

The information to be disclosed is marked by an X below:
_ Intake and discharge summaries _ Mental health evaluations
_ Progress notes, and treatment or closing summary
_ Developmental and/or social history _ Medical history and evaluation(s) _ Educational records
_ Any Protected Health Information _ Other:_____

HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: _ Do not release.

I have had explained to me and fully understand this authorization, and it is entirely voluntary on my part. I understand that I have a right to a copy of this authorization. I understand that I may cancel or modify this authorization by written notice, except to th extent that action based on it has already been taken. This authorization will expire automatically after one year from the dat of my signature, or upon fulfillment of the purposes stated above. A photocopy is as valid as the original.

_____	_____	_____
Signature of client or representative	*Printed name/(Relationship of representative to client)*	*Date*

__ **Please mail the records to Dr. Blankman.** __ **Dr. Blankman will telephone you to discuss the information.**

_ Copy for patient or representative _ Copy for source of records
_ Copy for recipient of records