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AUTHORIZATION TO RELEASE CONFIDENTIAL TREATMENT INFORMATION

I, (print your name) _____, hereby authorize and approve Dr. Mark D. Ackerman to discuss my treatment and/or release my confidential evaluation or treatment documents, including therapy notes and results from psychological evaluations and/or other documents acquired in the course of my evaluation or treatment with him to:

Name: E-Mail:

I understand that I may revoke this consent at any time by informing his office in writing. I agree these records may be released in any form, including electronically (e.g. e-mail format). In consideration of this consent, I hereby release Dr. Ackerman and his designated associates from any legal liability for the release of this information.

Signature _____ Date _____