AUTHORIZATION TO OBTAIN AND RELEASE CONFIDENTIAL INFORMATION

I, (print your name)_____, hereby authorize and request that Dr. Mark D. Ackerman, may discuss my treatment, and release all confidential psychological treatment and testing results, psychiatric, educational, and/or other records acquired in the course of my evaluation and treatments with him to:

I understand that I may revoke this consent at any time by informing the above parties in writing.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature _____ Date _____