Rachel Z. Goodman, Ph.D. (Permit # 10405-05)
Licensed Clinical Psychologist
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(514) 667-3830 #217

Consent to Release Confidential Information

I _____ hereby authorize and request Dr. Rachel Goodman to obtain/release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, concerning my treatment to/from:

Name: _____

Address: _____

Disclosure shall be limited to the following specific types of information:

_____

_____

Use of this information shall be limited to the following purpose(s):

_____

_____

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be effective and valid as the original.

This authorization shall remain valid until: _____

I further more release all parties stated her within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I agree to waive the 15 day delay for transmission of this consent: _____

Signature:_____ Date: _____