**Robert J. Berchick Ph.D.**
*433 East Street Road*
*Warminster, Pennsylvania 18974*

## AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

I, _____ hereby authorize Dr. Robert J. Berchick to **RELEASE** or **OBTAIN** To or
Print Name

From _____ _____
Doctors Name or Organization Doctors or Organization Phone Number

_____ _____
Doctors or Organization Street Address City, State and Zip

Copies of all psychological and medical or information about my (self or child) pertaining to (my or child's) treatment for

_____ during the period from _____ to
(specify condition) (specify dates)

_____.
(specify dates)

These records are required for the specific purpose of _____
(include specific reason (s) the records are needed )

_____ and the information

Requested or Released is limited to _____
( Exact information being requested will be identified)

I understand this consent is valid for ninety days. I understand that I may withdraw my consent (except to the extent that action has already been taken) at any time by writing.

I understand that, with a few limited exceptions listed in the HIPAA "Notice", Dr. Berchick nay not Obtain or Release records and/ or information about my (self/child) unless I agree to the request. I understand that under most circumstances I may look at the records and/ or information to be released. I understand the nature and the use of the material to be released. I understand that I give my permission for the records and/ or information to be Obtained From or Released To only the person or organization listed above, and only for the time and purpose shown above.

_____ _____
Signature of Patient Date

_____ _____
If a minor Signature of Parent/Guardian needed Date

C O N F I D E N T I A L