Dr. Nancy Kirsner, Ph.D., T.E.P., P.A., Certified Positive Psychologist

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AUTHORIZATION FOR RELEASE OF INFORMATION

TO:

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Date: ___________________________

RE: ___________________________
(Name of patient)

RELEASE TO:

I hereby authorize and request you to release to:

Dr. Nancy Kirsner

ALL or **RESTRICTED** (Circle one)
Medical, psychological, social, and educational information of the above-named patient.

RESTRICTIONS (Please be specific):

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RELEASE FROM:

I authorize Nancy Kirsner, Ph.D. to release **ALL** or **RESTRICTED** information concerning the treatment of the above-named patient.

RESTRICTIONS (Please be specific):

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____ ________________
(Name of professional or doctor) Date

____ ________________
(Signature of client) Date