Dr. Vicki Ehrlich

2039 Palmer Avenue, Suite 204

914-589-1161

Larchmont, NY 10538

CONSENT TO RELEASE PRIVELEGED AND CONFIDENTIAL INFORMATION

I hereby authorize _____to release to Dr. Vicki Ehrlich otherwise confidential information and/or records pertaining to (check one) ____ my case, _____ my child's case.

I also hereby authorize Dr. Vicki Ehrlich to confer with _____ and to discuss and/or release otherwise confidential information and records.

I intend this to be a (check one) _____one time only_____ continuous release. I understand that I may withdraw this consent at any time by indicating in writing that I wish to do so.

This release is subject to the following limitations:

_____

_____;

None _____

I am aware of the nature of the information to be released.

Signature: _____

Print Name: _____

Date: _____