Cynthia Mittelmeier, Ph.D.
240 Concord Ave Suite 2, Cambridge, MA 02138 (617) 876 1246

Consent to Release Information

This form authorizes me to release information to
persons or institutions that you designate.

Date: _____

Name: _____ DOB: _____
(please print clearly) *(MM/DD/YYYY)*

I authorize my psychologist, Dr. Cynthia Mittelmeier, to release the following information (*Provide description of the information that you want disclosed. Your description should be specific and detailed):*

_____

_____

This information should only be released to (*name and address of person to whom the information is to be released*):

1. _____
2. _____
3. _____
4. _____

I am requesting my psychologist to release this information for the following reasons *("at the request of the individual" is all that is required if you do not want to list a specific purpose*):

_____

This authorization shall remain in effect until _____(*expiration date, if desired*)

I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Mittlemeier at the above address. However, my revocation will not be effective to the extent that she has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Mittelmeier generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Signature of client/parent/legal guardian Date