ALICE R. BERKOWITZ, PH.D.
A Professional Psychology Corporation
Clinical And Forensic Psychology
8500 Wilshire Boulevard, Suite 700C
Beverly Hills, California 90211
Office: (310) 659-3824 Fax: (310) 659-9217

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ____

Phone:____________________ Fax:____________________ Email:_____________________
Address:____

____

to disclose and/or exchange Records and/or Information regarding:

____ Date of Birth ____ Mo.___ Day ____Year

____ Date of Birth ____ Mo.___ Day ____Year

____ Date of Birth ____ Mo.___ Day ____Year

To: **Alice R. Berkowitz, Ph.D. 9107 Wilshire Blvd, Ste 301, Los Angeles, CA 90210**

The disclosure of records authorized herein is requires for the following purposes:

☐ Social History ☐ Test Results ☐ Treatment Summary

☐ Diagnosis ☐ Medical History ☐ School Adjustment

☐ Educational Assessments and Behavioral Reports ☐ Other (Specify):

____

____

I understand that all client information is confidential and my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with. Without my expressed revocation, this authorization to you will automatically expire:

☐ Upon receipt of the information requested ☐ Under the following conditions:

____

____

Signature	Print Name	Date