*Marc L. Feldman, Psy. D., CAADC*

*111 Forrest Ave, Floor 2   
Narberth, PA 19072   
Phone: 610-675-5517*

Authorization Form

I authorize Dr. Marc L. Feldman to:

(please check one or both) release information \_\_\_\_\_\_\_\_\_\_

obtain information \_\_\_\_\_\_\_\_

(Provide specific information you want disclosed)

*\_*

This information should be released to or be requested from *(*name, address, and phone number of person(s) to whom the information is to be released/requested)

I am requesting the release of this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

This authorization shall remain in effect until (the date listed) or until (fill in an event that relates to the individual or   
the purpose of the use or disclosure):

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my   
office address. However, your revocation will not be effective to the extent that I have taken action in reliance on   
this 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. Marc L. Feldman may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

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Print Name of Client Signature of Client (age 14 & above) Date of Birth

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Print Name of Parent/Guardian Signature of Parent/Guardian Today’s Date

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Marc L. Feldman, Psy.D., CAADC