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Authorization Form

Name: _____

SSN: _____ DOB: _____

I authorize my psychologist, Susan Orenstein, Ph.D. to release this information for the following reasons:

"at the request of the individual"; or,
 for the following stated specific purpose _____

This information is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It should not be considered a blanket waiver of all privileged and confidential information.

This information should only be released to:

Name: _____

Address: _____

This authorization shall remain in effect

until _____ ; or until termination of treatment

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address.

This authorization is fully understood and is voluntarily made on my part.

Patient's Signature

OR _____
Parent/Guardian's signature

Date