DEBORAH M. ROSENBERG, PH.D.
Licensed Psychologist

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RELEASE OF INFORMATION

I,_____, agree to release clinical information from Deborah M. Rosenberg, Ph.D. regarding myself___my child___other family member_____TO _____
at address _____
And phone number_____.

_____
(client, parent or legal guardian signature)

_____
(date)

I,_____, agree to allow clinical information to be released to Deborah M. Rosenberg, Ph.D. regarding myself___my child___other family member_____FROM_____
at address _____
And phone number_____.

_____
(client, parent or legal guardian signature)

_____
(date)

I understand that I can withdraw this release permission at any time with a written letter to Dr. Rosenberg. ____
(initials)