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AUTHORIZATION TO RELEASE CONFIDENTIAL EVALUATION and/or TREATMENT INFORMATION

I, (print your name) ____, hereby authorize

and approve Dr. Mark D. Ackerman to discuss, coordinate care and/or provide a copy of my **evaluation or summary of my treatment** to the following individual(s):

Name: ______________________________ **E-mail**: ______________________________

Name: ______________________________ **E-mail**: ______________________________

I understand that I may revoke this consent at any time by informing Dr. Ackerman's office in writing. In consideration of this consent, I hereby release Dr. Ackerman and his designated associates from any legal liability for the release of my treatment/evaluation information to this individual.

Signature ____ Date _______________