**Jennifer B. Unterberg, Ph.D.**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) hereby authorize the release and/or exchange of information, between Jennifer B. Unterberg, Ph.D., and the people listed below. The purpose of this request is consultation and feedback. This authorization will begin on \_\_\_\_\_\_\_and expire on \_\_\_\_\_\_\_ or when I specify. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider. I understand that treatment may not be denied if I refuse to sign this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date

Please list the names of people with whom Jennifer Unterberg, Ph.D., is authorized to share information. You may add more names if necessary.

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Name/relationship to patient Phone number

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Name/relationship to patient Phone number

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