

**Jay H. Berk, Ph.D., Inc.**

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28001 Chagrin Blvd., Suite 212, Woodmere, OH 44122  
(216) 292-7170 FAX (216) 292-7182

**Request and Authorization to Release Records and Information**

This request hereby authorizes **Jay H. Berk, Ph.D.**, to obtain and or disclose information regarding:

\_\_\_\_\_ **Myself,** \_\_\_\_\_  
Your Full Name (Please Print) SSN DOB

\_\_\_\_\_ **My child,** \_\_\_\_\_  
Child's Full Name (Please Print) SSN DOB

**CHECK ONE OF THE FOLLOWING OPTIONS:**

\_\_\_\_\_ I grant permission to release all pertinent medical, psychological, or legal information pertaining to my child or myself.

\_\_\_\_\_ I grant my permission to release pertinent medical, psychological, or legal information pertaining to my child or myself with the following restrictions:

\_\_\_\_\_

**TO AND/OR FROM THE FOLLOWING PROFESSIONAL:**

\_\_\_\_\_ Name Title

\_\_\_\_\_ Organization (If Needed)

\_\_\_\_\_ Street Address City State ZIP

\_\_\_\_\_ Phone Number FAX Number

I voluntarily authorize and request to release/obtain information from my records and fully understand the nature of the records and information released.

I understand and acknowledge that this authorization extends to all or any part of the records designated above which may include documentation of treatment for physical and emotional difficulties, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. I expressly consent to the release of the information designated above.

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already occurred. **Such revocation must be in written form and dated.** This consent will expire automatically when treatment is concluded unless otherwise stated in writing.

\_\_\_\_\_ Signature of Patient or Parent/Guardian

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Witness

\_\_\_\_\_ Date