

Rebecca Elman, Ph.D., P.A.

**AUTHORIZATION TO DISCLOSE AND RECEIVE
CONFIDENTIAL INFORMATION**

Your communications and those of your minor child with Rebecca Elman are privileged and confidential. Except under limited circumstances provided by applicable law, the contents of such communications and the records relating thereto may not be disclosed or released without your prior written consent. Similar confidentiality obligations may apply to individuals/institutions who possess information that may need to be furnished to Rebecca Elman in the course of her providing services to your child. Accordingly, I hereby authorize Rebecca Elman to disclose confidential information relating to my minor child to, and receive confidential information relating to my minor child from:

Check all that apply:

(____) my child's school

Name of School and Teacher

Phone #, teacher's e-mail

(____) my child's doctor(s) (PLEASE PROVIDE NAME(S) AND PHONE NUMBERS)

Name

Phone Number

(____) other mental health providers (PLEASE PROVIDE NAME(S) AND PHONE NUMBERS)

Name

Phone Number

(____) other (PLEASE SPECIFY) _____

Child's Name: _____

Parent/Guardian's Signature: _____ Date: _____