Dr N Rebecca Fineman
883 No Shoreline Blvd
Ste C 120
Mountain View CA 94043
CA Lic # PSY14737

CONSENT TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

Date: ______________

________________________________ DOB:______________ is being evaluated/treated by N. Rebecca Fineman, Ph.D., 883 N Shoreline Blvd Suite C120 Mountain View, CA 94043 650 694 4678, Fax: 650 694 6754

I give my permission for:

( ) An exchange of information and records **between** Dr. Fineman and the individuals/agencies listed below (include telephone numbers):

( ) A release of records **from** Dr. Fineman to the individuals/agencies listed below:

( ) A release of records from the individuals/agencies listed below **to** Dr. Fineman:

Please send medical, educational, psychological and/or other pertinent information regarding this child and this child's family to Dr. Fineman at the above address.

Thank you for your prompt attention.

These releases are valid for one year from the above date. This voluntary consent may be revoked by the undersigned at any time, except to the extent that action based on this consent has already taken place.

_________________________________ _________________
Parent/Guardian

_________________________________ _________________