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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of all information relevant to the treatment of _____, Date of birth: _____.

This authorization applies to an exchange of information between Michael I. Vickers, PhD and _____. Such exchange may occur on one or more occasions, as is needed to complete the intended consultation successfully.

I understand that this authorization is valid until either treatment is ended or I submit in writing a request to discontinue this information exchange.

Signed (self)

Date

Signed (guardian)

Date