Michael Ascher, MD

191 Presidential Blvd Suite W10 / Bala Cynwyd, PA / 19004 / (646) 812-1421

AUTHORIZATION TO RELEASE INFORMATION

I, ___________________________________, hereby authorize Michael Ascher M.D. to exchange information with the following individuals.

____

NAME OF THERAPIST, PRIMARY CARE DOCTOR, LOVED ONES

____

PHONE NUMBER ABOVE CONTACT

_X_ All relevant and timely information may be released.

These records are required for the purpose of continuity of clinical care. This release will expire two year from the date signed unless otherwise noted.

I certify that I have read this form and that I understand its contents.

____

PATIENT SIGNATURE

____

DATE OF AUTHORIZATION

EMERGENCY CONTACT NAME AND NUMBER

____