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Tampa, FL 33618
(813)264-7314

Name:_____ Date: _____

I, _____, would like the following information:

Psychological Psychiatric Medical Educational

Other: _____

released to, shared between and discussed with:

1. _____

_____

Phone:_____ FAX_____

2. _____

_____

Phone:_____ FAX_____

This release will remain in effect for _____.

The purpose of this release is _____.

I understand I may request to terminate this release by contacting Dr. Barbara Feinberg in writing, but all materials that have already been released will be exempt.

_____ _____

Signed Date

_____ _____

Signed Date

Specialties: Families...Couples...Infertility Issues...Learning Disabilities...ADHD...Personality and Educational Evaluations...