Dana Schneider MA, MFT
***Psychotherapy * Divorce Related Issues * High Conflict Co-Parenting**
***Special Master**
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Authorization to Release Information

I, _____, DOB: _____, authorize the following specified agencies or individuals to exchange any and all medical, legal, forensic, educational, psychiatric, and psychological records and history with Dana Schneider MA, MFT, and for Ms. Schneider to freely exchange information about me with them:

- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____
- ❑ _____
  phone_____ fax_____

I understand that this release will automatically expire one year from the date below.

Signature: _____

Date: _____