Erene Soliman Psychologist, Inc.
Licensed Psychologist, PSY23162

Permission to Exchange Information

Client Name: _____

DOB_____

S.S.N._____

I give express permission for Dr. Erene Soliman to **exchange and dialogue** with the party listed below the following information. I understand that this is a release of information both **to and from** Dr. Soliman and the party listed below. I also understand that this release is for the period of one year, and that I may revoke it at any time.

Party (name and phone number) with whom information **may be shared or requested from:**

_____

_____

_____

Specific limitations on information to be exchanged:

_____

_____

_____

Signature of Client: _____

Date: _____

Witness: _____

5151 N Palm Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733
esolimanpsychservices.com