Alexey Tolchinsky, Psy.D.
License # 05705

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Release of Information Agreement

I authorize Alexey Tolchinsky, Psy.D., a licensed psychologist, address above, to:
___/ receive the following information:
___/ release the following information:

_____

___/ from the following party:
___/ to the following party:

_____

_____
for the following purpose:

_____

This release applies to __/ myself __/my child, _____, date of birth ___/___/___ . It ___/ will ___/ will not further allow Dr. Tolchinsky to communicate orally about this information with the party or parties listed above. I understand that I can revoke this consent at any time by notifying Dr. Tolchinsky. This release will expire one year from the date of signature, and is governed by relevant provisions of Maryland law.

Signature:_____Date:_____

Printed Name:_____