



## Release

I, \_\_\_\_\_ give permission to Dr. Judy Rosenberg to speak with and/or obtain medical records from my other health care professionals, including my primary health care provider.

Patient Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PSYCHOLOGICALHEALINGCENTER**

Judy Rosenberg, Ph.D.

Psy14817

15615 Castlewoods Drive, Sherman Oaks, CA 91403  
152 S. Lasky Drive Ste 208 #D, Beverly Hills, CA 90212  
www.psychologicalhealingcenter.com  
310.739.4491