Limited Release of Information

In order to facilitate your care, it is important that your psychiatrist and psychotherapist be allowed to communicate with each other regarding your psychiatric condition and its treatment. By signing this form you specifically give your permission for your psychiatrist (named below) and your psychotherapist (named below) to discuss all aspects of your treatment including mental illness, physical illness, psychotherapy, and substance abuse. Such communication may be written or oral. This consent will remain in effect until canceled by you or for sixty days after termination of your treatment here, whichever is less.

Psychiatrist name: Peter J. Weingold, M.D. phone #: (310) 854-0183

Therapist name: ______________________________ Phone #: ________________

Date: ___________

I consent to the above release of information:

Patient name: ________________________

Patient signature: ____________________

I do not consent to the above release of information:

Patient name: ________________________

Patient signature: ____________________