Ildiko Tabori, PhD
Psychologist
CA PSY19688

Authorization for Disclosure of Information

I, ____, hereby authorize the release of information regarding myself, my treatment, and/or any psychological or neuropsychological evaluations:

From Ildiko Tabori, PhD to: ____

____
Phone and/or Email

And / Or

To Ildiko Tabori, PhD from: ____

____
Phone and/or Email

For the purpose of:

____

____

I understand that I may revoke this consent at any time by informing the Office of Dr. Ildiko Tabori in writing.

Signature: ________________________________ Date: ______________

Print Name: ____

Expiration of Consent: ____