Marie Margenau-Spatz, Ph.D.

GENERAL RELEASE AND AUTHORIZATION FOR MEDICAL INFORMATION AND STATEMENT OF OFFICE POLICY

I hereby authorize Marie Margenau-Spatz, Ph.D. to release any medical information or psychological information necessary for my treatment and to discuss said information with managed care organizations or any other insurance carrier or agency where I am or was insured under a policy presently or formerly in effect.

I agree to pay for all scheduled office appointments on the day and at the time of the appointment. I acknowledge nonce of and I agree to the foregoing cancellation policy, to wit: I agree to pay for all scheduled office or telephone appointments even if I do not attend the appointment for any reason, unless I cancel said appointment not less than forty-eight (48) hours prior to the time of the scheduled appointment.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim(s) or term of treatment including a reasonable time thereafter until its final consummation. This authorization shall be binding upon me, my dependents and our heirs, executors and administrators. A photocopy of this authorization shall be considered as effective and valid as the original.

(Please print) _____
Insured / Patient Name

(Please sign) _____
Insured / Patient Signature

_____2009
Date

Offices:
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Westchester: 29 Hughes Terrace. Yonkers, NY 10701-1744 Tel: 914-963-1636 Fax- 914-963-3336
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