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**Authorization to Exchange Confidential Information  
With another provider**

In order to better serve me and to provide thorough and comprehensive treatment my provider, Tina Ventura Glueck, Ph.D., has requested to discuss my case and exchange clinical information with

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I willingly choose to release this information for the purpose specified above and I understand that I may revoke this release at any time except to the extent that action has already been taken in response to my consent.

A photocopy or fax of this release is to be considered as valid as the original.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_