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AUTHORIZATION FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Permission is hereby given to Elyse Corbett, Ph.D. to ( ) release ( ) request information for professional use from the records of:

_____

Client Name

This authorization includes the release of psychological and/or psychiatric information (may be part of the medical record). Person/organization which information is to be ( ) released ( ) requested

_____

Name Address

FROM THE PERIOD: _____ TO _____ (12 months unless specified)

The type of information is limited to (check at least one)

( ) intake summary/report ( ) psychological evaluation(s) ( ) medical record

( ) discharge summary/report ( ) confirmation of services ( ) other

( ) treatment summary ( ) drug and alcohol issues

( ) any and all information ( ) entire psychological record

_____

( ) with the following exceptions

I hereby authorize the following (signer to initial for authenticity)

_____ Release of my records via FAX machine. I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company.

I understand that I may revoke this consent at any time by notifying my therapist in writing EXCEPT to the extent that action may have already been taken in reliance on my consent. I also hereby release Elyse Corbett from any liability in connection with the release of the above information.

_____ _____

Client or Parent/Guardian Signature Date

_____ _____

Address Date of Birth

_____ _____

Last 4 digits of SSN

_____ _____

Witness Signature Date