AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

A. CLIENT INFORMATION

Client's Name: ______________________ Date of Birth: _____/_____/___________

B. AUTHORIZATION, INFORMATION TO BE RELEASED, AND PURPOSE OF RELEASE

By signing this form, I (name), ____, authorize Warner Psychology Associates, LLC to release confidential information about me or the person listed above (for whom I serve as the legal guardian/ representative). I authorize Warner Psychology Associates, LLC to release such information to:

____

Person/Agency

____

Address and Phone/Fax Number

I authorize release of the following confidential information:

____ *Any and all* information included in the case file/records or otherwise known to Warner Psychology Associates, LLC

____ Specific information limited to the following:

____

____

The purpose of this release (i.e. sharing of information) is to:

____

____

Unless I request otherwise, I understand this Authorization remains in effect for a year beyond the date it is signed. I have the right to revoke, or end, this Authorization by providing Warner Psychology Associates, LLC with a written request to end the Authorization. Any such revocation would be effective upon receipt of such a request.

C. ACKNOWLEDGEMENT OF RECEIPT

I have read this form (or had it read to me) and understand the terms of this Authorization. I have had an opportunity to ask questions about the release of confidential information. I understand I can refuse to sign this Authorization.

____ ____________________

Signature of Client or Client's Legal Representative Date

____ ____________________

Signature of Witness Date