Authorization for Release/Request of Confidential Information

Permission is hereby given to Julien T. Perille, Psy.D. to release and/or exchange information for professional use from the records of:

Client Name

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

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

[ ] any and all information [ ] psychological evaluation(s) [ ] discharge summary/report [ ] confirmation of services

[ ] treatment summary [ ] drug and alcohol issues

[ ] intake summary/report [ ] other:

[ ] with the following exceptions

The information should be released to, received from, and/or exchanged with:

Name

Address

Telephone and Fax

This authorization shall remain in effect until. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this consent at any time by notifying my therapist, Julien Perille, Psy.D., in writing. I also hereby release Julien Perille, Psy.D., from any liability in connection with the release of the above information.

Client Full Name Date of Birth

Address

Client Signature Date

Witness signature Date