Christine A. Baser, R.N., Ph.D.
A Professional Psychology Corporation

Release of Information

Please sign the statement below giving your permission for me to communicate with the following individual, agency, or insurance company on your behalf:

_____
(name of individual, agency, company to be contacted)

_____
(address, city, state, zip of said individual, agency, company)

_____
(phone/fax)

I, _____ , born on _____, hereby authorize
(name of patient) *(birthdate)*

_____ to disclose/obtain (circle one or both) the following
(name of doctor)

information from clinical records.

☐ Diagnosis and dates of treatment ☐ Summary of treatment
☐ Psychological evaluation/assessment ☐ Relevant treatment records
☐ Other_____

about me/my child, _____
(child's full name)

for the following purpose: _____

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

Patient Name/Guardian Name _____

Patient/Guardian Signature _____ Date _____

Relationship to patient:

☐ self
☐ guardian
☐ parent of a minor
☐ person legally authorized to act on the behalf of the patient.