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**Authorization to Release Information**

Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the exchange of information between:  
(print your name)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

And Daniel J. Richard, Ph.D.  
1044 Central St. Suite 201  
Stoughton, MA. 02072

**It is my understanding that this information will be used solely for the purposes described below. I understand that I may revoke my permission at any time except after the information has already been released. This authorization will expire on \_\_\_\_\_ or when therapy ends.**

**Portion of record to be released:**

- \_\_\_ Medical Record
- \_\_\_ Psychological Test Report
- \_\_\_ School Record
- \_\_\_ Summary of contact
- \_\_\_ Other (specify) \_\_\_\_\_.

\_\_\_\_\_  
(date) (Patient's Signature)

\_\_\_\_\_  
(date) (Legal Guardian, if applicable) (Relation to Patient)

\_\_\_\_\_  
(date) (Witness)

**I understand that the information, which I am authorizing to be released, is drug/alcohol related information and is protected by Federal Regulations 42CFR.**

\_\_\_\_\_  
(date) (Patient's Signature)

\_\_\_\_\_  
(date) (Legal Guardian, if applicable) (Relation to Patient)

\_\_\_\_\_  
(date) (Witness)

