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Authorization to Release Information

Name: _____ Date of Birth: _ _/_ _/_ _ _ _

Address: _____
_____
_____

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

_____
_____
_____
_____
phone number:_____
fax number:_____

And

Daniel J. Richard, Ph.D.
125 Church St. Suite 170
Pembroke, MA. 02359

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)