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Authorization to Release Information

Name: _____ Date of Birth: __/__/____

Address: _____

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

Daniel J. Richard, Ph.D.
And 720 Washington St. Suite 203
Hanover, MA. 02339

phone number: _____
fax number: _____

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)

