Authorization to Release/Obtain/Exchange Confidential Information

In order for Dr. Amanda Lawson-Ross to release, obtain, or exchange confidential information, this authorization must be fully completed. For your protection, if this form is incomplete or not legible, or if I cannot reach you by phone to discuss your request, I may not release or request the release of any information. Disclosure of your records cannot be made without your written consent, unless otherwise provided by law, and that you may revoke this authorization in writing at any time, except to the extent that information has already been released. Dr. Lawson-Ross cannot guarantee confidentiality of information after it is released.

(1) Client's Name_____ Birthday_____

Full Address_____

(2) I voluntarily authorize Dr. Amanda Lawson-Ross to (choose one option):

☐ Release Information To, ☐ Obtain Information From, or ☐ Exchange Information With

(3) Full Name_____ Agency/Department_____

Full Address_____

Telephone_____ Fax_____

(4) Check all that Apply:

☐ A letter to include the following:
☐ Confirmation of dates of attendance
☐ Dates and types of services received
☐ Other (Specify): _____
☐ Complete medical records
☐ Results of assessment and recommendations
☐ Diagnosis and treatment progress

(5) The purpose for releasing this information is: _____

_____

(6) This authorization expires in one year from the date of signature.

_____

Client Name | Client Signature | Date

_____

Guardian/Responsible Party Name | Signature | Date