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Heal. Grow. Empower. Healing Families. Growing Relationships. Empowering Individuals.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Shirley Boone-Sanford, Ph.D.

To release to To obtain from To communicate with

The following information (check appropriate box):

- | | | |
|---|---|--|
| <input type="checkbox"/> Psychological Report | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Psychological Test Data |
| <input type="checkbox"/> Progress Report | <input type="checkbox"/> Treatment Summary Report | <input type="checkbox"/> Clinical Notes |
| <input type="checkbox"/> Other | | |

The information is needed for the purpose of:

- | | |
|--|---|
| <input type="checkbox"/> Continued Treatment | <input type="checkbox"/> Consultation Purpose |
| <input type="checkbox"/> Utilization Review | <input type="checkbox"/> Consideration of Payment |
| <input type="checkbox"/> Other | |

After giving due consideration to the extent of this release, I authorize Dr. Boone-Sanford to furnish information, including photo static copies of my psychological records concerning my evaluation or treatment, to the above individual, organization or to its agents, and I further agree to indemnify and hold harmless Dr. Boone-Sanford from all liability that may arise from the release of the information herein requested. Any information released in response to this authorization should not be re-released to any other person(s) unless I so specifically authorize.

I understand that the records released may contain alcohol and drug treatment information, medical information, AIDS/HIV information, or psychiatric and psychological information. I understand that my records may be protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42, CFR Prt. 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it, and that in any event this authorization is valid for a period of 180 days from the date of my signature.

Client Name (Print)

Date

Client/Guardian

Date