

Colette Lord, Ph.D.

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby request and authorize _____
Name of Person or Agency

Address Phone

and Colette Lord, PhD, to exchange all pertinent records and information concerning the psychological and/or medical history with each other regarding the below listed client in order to:

- coordinate care
- facilitate transition related treatment & procedures
- obtain history of care
- other: _____

The information to be released includes:

- intake assessment
- HIV related info
- any and all info
- progress notes
- other: _____
- drug/alcohol history
- NOT to include: _____

This release shall remain in effect until **one year** from the date signed unless revoked in writing by the undersigned at any time. Records obtained pursuant to this release shall not be re-released by the recipient or used for anything other than the intended use (as indicated above).

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Colette Lord, Ph.D., from any and all liability arising from the release and disclosure of the information and records to the above designated person or agency.

I am signing this authorization voluntarily; I understand my treatment will not be affected if I do not sign this authorization. I understand that I have the right to receive a copy of this authorization.

Printed Name Client

Date of Birth

Signature

Date Signed