Colette Lord Ph.D. Psychologist Inc.

Phone: (858) 276-8831 Fax: (833) 342-3792 Email: me@colettelordphd.com

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby request and authorize _____
Person / Agency Relationship

_____
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 mental health info
___ progress notes ___ other: _____
___ drug/alcohol history ___NOT to include: _____

This release shall remain in effect until **<u>one year</u>** 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). This authorization may be revoked at any time.

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. Psychologist Inc. 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