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AUTHORIZATION FORM: RELEASE/EXCHANGE/REQUEST OF INFORMATION

Client Name(s): _____ DOB: _____

I authorize my psychologist, W. Michael Rogers, Psy.D, and/or W. Michael Rogers, Psy.D., P.L.L.C. to release/exchange/request the following information verbally and in writing to:

Name(s): _____ Phone: _____

Address: _____

Relationship to Client: _____

Type of information to release/exchange/request (Please initial):

_____ Screening/Intake Information _____ Behavioral/Psychological Reports _____ Medical Records

_____ Treatment Plan _____ Psychotherapy/Counseling Notes _____ Laboratory Records

_____ Other: _____

Purpose of release/exchange/request (Please initial):

_____ To provide services and/or care _____ Other purpose: _____

This authorization shall remain in effect until (Expiration date): _____

This authorization may be revoked at any time by signing where indicated below. The only exception is when action has been taken in reliance on the authorization. Unless revoked this release shall remain in effect for the period reasonably needed to complete the request. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

Signature

Date

W. Michael Rogers, Psy.D.

Date

Signature to revoke this authorization

Date