

Authorization to Release Information

Permission is hereby granted to Stephen Brewer, PsyD to request or send to:

Name: _____

Address: _____

City/ State: _____

Telephone: _____ Relationship: _____

the following information regarding:

Client Name: _____ Date of Birth: _____

Diagnosis Psychological Evaluation

Developmental History Treatment Plan

Medical History Treatment Summary

Progress Notes Discharge Summary

Other: _____

This information will be used for the purpose of: _____

I release Stephen Brewer, PsyD from legal liability arising from the release of this information. I understand that this authorization is valid until _____ and may be revoked before that time if I request so in writing, except to the extent action has been taken in reliance upon this consent.

Client Name (please print): _____

Client Signature: _____

Date: _____

Any individual or agency receiving this information is prohibited from making further disclosure of this information except where permitted by law.