Christopher Emerson, Ph.D.
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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ___________________________________

Date of Birth: ___________________

This release of information form authorizes information from my records to be shared between Christopher Emerson, Ph.D., and the person or agency listed at the bottom of this form. The information to be shared is to be used for the purpose of conducting review of evaluations, treatment plans, progress notes, discharge planning, and information for the authorization of reimbursement.

I give permission to Dr. Emerson to share the following information with

____:

____ Legal ____ Psychiatric ____ Medical ____ Social

____ Psychological (testing) _____ Financial _____ Other ____ All

I understand that this authorization is valid for six months from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Signature: _________________________________ Date: ______________

Address: ____

____

I hereby revoke above consent.

Signature: _________________________________ Date: ______________