

## AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I \_\_\_\_\_ authorize Karen Culbertson to:

\_\_\_\_\_ release to:

\_\_\_\_\_ obtain from:

\_\_\_\_\_ exchange with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

the following information pertaining to myself:

\_\_\_\_\_ treatment summary

\_\_\_\_\_ history/intake

\_\_\_\_\_ diagnosis

\_\_\_\_\_ psychological test results

\_\_\_\_\_ psychiatric evaluation/medication history

\_\_\_\_\_ dates of treatment attendance

\_\_\_\_\_ other (specify) \_\_\_\_\_

for the purpose of:

\_\_\_\_\_ evaluation/assessment and/or coordinating treatment efforts

\_\_\_\_\_ other (specify) \_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event \_\_\_\_\_

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Sign → \_\_\_\_\_ Today's Date \_\_\_\_\_

Print Name \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_

Witness Sign → \_\_\_\_\_ Witness Name \_\_\_\_\_