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Kristine M. Berrett, Ph.D.

Licensed Psychologist

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. CLIENT_____

ADDRESS_____ HOME PHONE_____

_____ WORK PHONE_____

BIRTHDATE_____ SOC. SEC. NO._____

NAME OF GUARDIAN (IF CLIENT IS MINOR)_____

2. I, AUTHORIZE: TO RELEASE TO:

NAME_____ NAME_____

MAILING ADDRESS_____ MAILING ADDRESS_____

_____ _____

_____ _____

PHONE_____ PHONE_____

3. INFORMATION TO BE RELEASED:_____

_____

_____

4. PURPOSE OF DISCLOSURE:_____

5. THIS AUTHORIZATION SHALL BE IN EFFECT FOR 12 MONTHS FOLLOWING THE DATE OF THE SIGNATURE.

6. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY NOTIFYING KRISTINE BERRETT IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE ON IT AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED ABOVE.

7. I UNDERSTAND THAT INFORMATION DISCLOSED UNDER THIS AUTHORIZATION MAY BE DISCLOSED AGAIN BY THE PERSON TO WHICH IT IS SENT. THE PRIVACY OF THIS INFORMATION MAY NOT BE PROTECTED UNDER FEDERAL PRIVACY REGULATIONS.

8. **A PHOTOCOPY IS AS VALID AS THE ORIGINAL.**

I AUTHORIZE THE RELEASE OF THE INDICATED SENSITIVE RECORDS ALSO (INITIAL):

Mental Health Records_____ Chemical Dependency_____

Psychological Test Scores_____ HIV or AIDS_____

SIGNATURE OF CLIENT OR GUARDIAN_____

DATE_____ WITNESS_____