

REQUEST/AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby consent to, direct and authorize Dr. Ashley Hoffman to () provide, () obtain, or () exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Ashley Hoffman and/or to the following person or agency:

_____ of _____
(Name) (Address and Telephone or Fax Number)

The information or records to be released or disclose include:

- _____ Initial Evaluation/History
- _____ Psychiatric/Psychological Reports
- _____ Medical Information
- _____ Therapy Notes
- _____ Billing Records
- _____ Transfer/Termination Summary
- _____ Tests Taken and Testing Scores
- _____ Other (specify): _____
- _____ Any and all records/information

The purpose of this authorization:

- ___ Facilitate evaluation or treatment
- ___ Provide information for insurance purposes
- ___ Provide information for a legal matter
- ___ Other: _____

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Ashley Hoffman and her staff from any person and all liability arising from release and disclosure of the information and records to the above named person.

Client Name (Printed) Client Signature Date

Client Telephone Number Client Address DOB

Witnessed by:

Ashley Hoffman, Psy.D. (Or Printed Name of Witness) (Signature of Witness)