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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize Dr. Lora Baum
(Name of Patient)

to disclose to _____
(Organization/Provider to which disclosure is to be made)

for the purpose of clinical consultation and continuity of care the following information:

- Psychological evaluation
- Clinical formulation
- Diagnostic impressions
- Treatment plan
- Psychological test results (if any)

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND STATE CONFIDENTIALITY REGULATIONS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THE REGULATIONS. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT (E.G., PROBATION, PAROLE, ETC.) AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW.

Specification of the Date, Event, or Condition Upon Which This Consent Expires:

_____.

Granted This _____ Day of _____ , 20_____

_____ _____
Signature of Patient Birthdate

_____
Signature of Witness