Sherry Reeves, Psy.D.
Licensed Clinical Psychologist
870 Clark Street, Suite 1020
Oviedo, FL 32765
407-701-1135 phone • 407-542-1804 fax

AUTHORIZATION AND REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____, hereby grant Dr. Reeves permission to (check those that apply):

( ) release my records to the person/organization listed below
( ) release my child's records to the person/organization listed below
( ) request records from the person/organization listed below
( ) speak to the person/organization listed below
( ) write a letter to the person/organization listed below

____
Name of person/organization receiving information or records

____
Address and/or phone number of the above named person/organization

Records/information will include medical/psychological/neuropsychological, behavioral, alcohol, and/or drug abuse information and/or school records.

Patient Name: ____

Address: ____

Date of Birth: ______________________________ SS#: ______________________________

I issue this authorization with a knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.
I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication. This authorization will expire one year after I terminate treatment with the above named party, unless revoked by me earlier in writing.

______________________________	____________________	______________
Signature of patient/parent/legal guardian	relationship to patient	date
______________________________	____________________	
Witness signature	date	

(If this authorization is signed by someone other than the patient, except if the patient is a minor, a copy of the legal document of guardianship or power of attorney must be attached)