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AUTHORIZATION FOR RELEASE/REQUEST OF CONFIDENTIAL INFORMATION

Permission is hereby given to Caitlin Shepherd, Ph.D. to [ ] release [ ] request information for professional use, from the records of:

_____

Client Name

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

Person/organization to/from which information is to be [ ] released [ ] requested

_____

Name

_____

Address Phone Fax

FROM THE PERIOD: _____ TO _____ (12 months unless specified)
The type of information is limited to (check at least one):

[ ] intake summary/report	[ ] psychological evaluation(s)	[ ] medical record
[ ] discharge summary/report	[ ] confirmation of services	[ ] other
[ ] treatment summary	[ ] drug and alcohol issues	
[ ] any and all information	[ ] entire psychological record	

_____

[ ] with the following exceptions

I understand that I may revoke this consent at any time in writing EXCEPT to the extent that action may have already been taken in reliance on my consent. I also hereby release Caitlin Shepherd from any liability in connection with the release of the above information.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Caitlin Shepherd, Ph.D. Date