**Iverson M. Eicken, Ph.D.**
1008 5th St. ◈ Santa Rosa, Ca. 95404 ◈ (707) 775-5666 ◈ Dr_Eicken@hotmail.com

# Authorization to Release & Request Confidential Records and Information

I, _____ whose date of birth is: _____

whose address is: _____
Street City State Zip
and whose Social Security number is: _____ ;

authorize Iverson M. Eicken, Ph.D. to exchange information with:

_____
Name/Agency

_____
Street City State Phone

The information I authorize to be exchanged includes, but may not be limited to: Intake and discharge summaries, medical history and evaluation, diagnostic impressions, dates of treatment, mental health evaluations, developmental and/or social history, medical information, educational records, and progress notes. This information will be used for mental health evaluation, treatment planning, and continuity of care.

Please forward the records to: Iverson M. Eicken, Ph.D.
1008 5th St.
Santa Rosa, Ca. 95404

(707) 775-5666

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____ _____
Signature of Client Date