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Authorization to Release Information

I, _____, authorize Stefanie A. Gray, Ph.D., to disclose, release, and/or obtain records or information re: _____ to/from:

(Check if yes)		Name	Phone	Fax
	My primary care physician			
	My family member(s)			
	My lawyer			
	My child's school			
	The person who referred me			
	My previous therapist			
	Psychiatrist			
	Dietician			
	Hospital Medical Records			
	Other			

Specific purpose/Information concerning:

_____

_____

Such records or information may include (but are not limited to) test results and/or reports, diagnostic impressions, medical treatment records, academic records, and all other information available. I authorize this to be in either written form or relayed verbally for the purposes of evaluation and/or treatment for a period of one year from the date of my signature. I further understand that this authorization may be revoked by me at any time. A copy of this release is further authorized to be valid as original.

Signature: _____ Date: _____
Relationship to Patient: _____