Dr. Annkatrine Gates, Psy.D - Clinical Psychologist - Tel: 617-800 - 9469

**Authorization to Release Confidential Information**

Client Name:

DOB:

Address:

Phone/Email:

Other Clinician, Institution or Person releasing Records or Information:

Address:

Phone/Email:

I hereby authorize the following information to be released **TO** Annkatrine Gates, Psy.D.

* Mental Health Evaluation & Treatment Records
* Psychological, Neuropsychological, Developmental & Academic Testing Reports
* Medical Evaluation & Treatment Records
* Telephone consultation regarding past or current medical or mental health treatment
* Other

I hereby authorize the following to be released **BY** Annkatrine Gates, Psy.D.

* Mental Health Evaluation & Treatment Records
* Psychological, Neuropsychological, Developmental & Academic Testing Reports
* Medical Evaluation & Treatment Records
* Telephone consultation regarding past or current medical or mental health treatment
* Other:

I have read and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including alcohol and Drug Abuse Records, if relevant, to/by those agencies named above. I understand that this information may be protected by Federal regulation 42 CFR Part 2. I understand that this consent is subject to revocation at any time except regarding information that has already been released, and will expire one year from the date signed below.

Date and Signature of the Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian may only sign for client aged 15 years or younger, patient and parent must sign for patient aged 16-17 years.)