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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Christopher H. Lane, Ph.D. by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Christopher H. Lane, Ph.D. to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself/my child _____:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ clinical impressions
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

Unless extended in writing, this consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

Unless compelled by Court Order or by any other written agreement, I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date OR
Date of Birth:_____