Julie Bingham Ph.D.
Licensed Clinical Psychologist

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Authorization to Release Confidential Information

Name of Patient _____ Birthdate_____

I, the undersigned, authorize the release of, or request access of my confidential medical record(s) of the above mentioned patient from Dr. Bingham to the person or organization listed below

_____

(doctor, hospital, attorney, insurance company, etc) Phone/Fax number

_____

Address (Street, City, State and Zip)

This confidential information may be released for the following reasons

- Continuing Medical Care
- Other : _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taking in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized representative

_____
Printed name of Patient or Legally authorized representative