VIVO Clinical Forensic Psychological Services, Inc.
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CONSENT/AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ of _____
Name of client Address

_____
City, State, Zip

authorize the release or exchange of information between **Miranda Dewitte, PsyD.** and

_____
Name of Individual or Organization

_____
Address/Telephone/Fax Number

The following information is to be released related to any and all documents for:

Treatment history ☐
Treatment summary ☐
Treatment plan ☐
Discharge summary ☐
Legal Records: ☐
Test results ☐
Medical History ☐
Family history ☐
Medication history ☐
Employment Records: ☐

Other _____
The information is to be released for the following reason(s):

_____

I understand that my records are protected under Federal and State confidentiality regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this authorization is effective immediately and I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event the consent expires in 1 year unless I renew it. I further acknowledge that this information to be released was fully explained to me, this consent is given of my own free will, and I release the clinician, Miranda Dewitte, PsyD, from any liability arising from the released information presented to the persons/agency designated above.

Specification of date, event, or condition upon which this consent expires: _____or 1 year from date signed. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date