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RELEASE OF INFORMATION

Your signature given permission allows me to communicate with the following individuals, agencies, or insurance companies on your behalf:

____
Individual/s or group to be contacted

Located at ____

Phone______________________________ FAX __________________________.

I ____________________________________, born on ______________________
(Print your full name)

Hereby authorize ____Dr. Adria O'Donnell__ to **disclose/obtain** (circle one or both) the following information from clinical records:

____ Entire Record
____ Summary of treatment
____ History & background
____ Complete treatment records
____ Diagnosis & dates of treatment
____ Psychological Evaluation
____ HIV status, if relevant
____ Substance abuse history
____ Other____

about me/my child ____
(child's full name)
for the following purposes:____
____

This authorization and request to disclose or obtain information from records will expire **one (1) year** from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

_____________________________Date_______ _____________________________
Printed Name Signature of client/guardian

Relationship to client: ____ Self ____ Guardian ____ Parent of Minor
____ Person legally authorized to act on behalf of client