DOUG GIRARD, Psy.D.

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Information:

Client Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Email: _____

Authorization to release confidential information:

I hereby authorize Doug Girard, Psy.D. to:

☐ disclose ☐ receive ☐ exchange

the following confidential information from my records in verbal, electronic, and/or written form:

_____

_____

_____

(Please provide a description of the information to be disclosed, received, or exchanged.)

Person/institution with whom information is to be disclosed, received, or exchanged:

Name: _____ Agency: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Email: _____ Other: _____

I am requesting that information be disclosed, received, or exchanged for the following reasons:

_____

_____

_____

("At the request of the individual" is all that is required.)

This authorization shall remain in effect until: _____

(Please note that the date may not exceed one year.)

I understand that Dr. Girard cannot re-disclose information he receives from another health care provider if that health care provider requested that the information not be re-disclosed. I further understand that I may revoke this authorization at any time by sending written notification to Dr. Girard.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____ _____

Signature of client Date