

AUTHORIZATION TO EXCHANGE INFORMATION FORM

Client Name _____ DOB _____

Address _____

I, _____

Client Name Self-if over 16 in MD or over 14 in DC or /parent/legal guardian)

authorize Ron Wynne, PhD, ABPP and

to exchange the following written and verbal information about my or my child's treatment (please check all that apply):

- Notification of beginning and/or ending of treatment
- Periodic summary of treatment progress
- Coordination of service agreement/treatment planning
- Educational information/records
- Past Treatment
- Intake assessment Summary
- Psychological Evaluation
- Financial information
- Discharge Summary
- Current psychiatric diagnosis
- List of current psychotropic medications and dosages
- Other (specify): _____

The purpose of the disclosure authorized herein is to (specific purpose of the disclosure):

*This information release consent is given freely, voluntarily, and without coercion, and may be withdrawn by me at any time. Any information I authorize others to release to Dr. Wynne will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. I have the right to inspect the record or mental health information on the above-named individual. **This authorization is effective for one year from the date below.***

Signature of Client over 14 (DC) 16 (MD)

Date

Signature of Parent/Legal Custodian of Minor

Date