Amber Learn, Psy.D.

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Clinical Psychologist PSY25444

Authorization for Release of Information

I, _____, (_____), do hereby authorize Dr. Amber Learn to exchange information
First, Middle, Last Name DOB

contained in my medical record, in either verbal or written form, and/or by fax, with:

Name of Person or Agency: _____

Address: _____
Street Address City State Zip

Telephone: _____ Fax Number: _____

Permission is hereby granted to provide information to the above specified person(s) or agency regarding:

_____ COMPLETE RECORD _____ VERIFY TREATMENT ONLY

_____ TREATMENT SUMMARY _____ PSYCHOLOGICAL TESTING

_____ FOR PURPOSE OF: _____

I give permission for information to be released in written or verbal form, or via fax, to the above specified individual or to personnel at the above specified agency. I understand that this Authorization will expire one year from the date of signature below, unless specified otherwise. I understand that I have the right to request an accounting of any instances that information is released to other parties. I understand that this Authorization may be revoked at any time.

Signature: _____ Date: _____

Witness: _____ Date: _____

FOR INTERNAL USE ONLY
(document date and reason for revoking release of information)

Date Revoked: _____ Signature: _____