AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize the Lori Volpe to:

___ release to: _____
_____
_____

___ obtain from: _____
_____
_____

___ exchange with: _____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____
Signature of Client Date

_____
Signature of Witness Date