Ashley Hoffman, Psy.D

Licensed Clinical Psychologist

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REQUEST/AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby consent to, direct and authorize Dr. Ashley Hoffman to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Ashley Hoffman and/or to the following person or agency:

_____ of _____

(Name) (Address and Telephone or Fax Number)

The information or records to be released or disclose include:

_____ Initial Evaluation/History
_____ Psychiatric/Psychological Reports
_____ Medical Information
_____ Therapy Notes
_____ Billing Records
_____ Transfer/Termination Summary
_____ Tests Taken and Testing Scores
_____ Other (specify): _____
_____ Any and all records/information

The purpose of this authorization:

__ Facilitate evaluation or treatment
__ Provide information for a legal matter
__ Provide information for insurance purposes
__ Other: _____

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Ashley Hoffman and her staff from any person and all liability arising from release and disclosure of the information and records to the above named person.

_____ _____ _____

Client Name (Printed) Client Signature Date

_____ _____ _____

Client Telephone Number Client Address DOB

Witnessed by:

_____ _____ _____

Ashley Hoffman, Psy.D. (Or Printed Name of Witness) (Signature of Witness)