James Hopper, Ph.D.
Arlington, Massachusetts
Fax: 888-316-2125

Authorization to Obtain/Release Information

Client: _____ Date of Birth: _____

Address: _____

_____

I authorize James Hopper, Ph.D. to:

( ) Obtain from ( ) Release to

Name: _____

Facility: _____

Address: _____

_____

Phone: _____

The following information contained in the record of the client named above concerning services provided on or about _____.

Please check the appropriate information to be released:

( ) Verbal communication about ongoing or prior treatment
( ) Admission Note
( ) Discharge Summary
( ) Psychological Testing
( ) Treatment Plans/Summaries
( ) Consultations
( ) Notification of the primary care physician that I have requested behavioral health services
( ) Other: _____
( ) I agree that a copy of this form is valid as the original.

I have carefully read and understand the above statements and expressly and voluntarily consent disclosure of information or records about my condition and treatment.

I understand this consent can be revoked at any time unless action based on it has already begun. The authorization expires one year from the date written below:

Date: _____ Signature of Client: _____

Date: _____ Signature of Witness: _____