Amy Horne, Ph.D.

Clinical Psychologist

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RELEASE OF INFORMATION

Please sign the statement below giving your permission for me to communicate with the following individual, agency, or insurance companies on your behalf:

_____

(Name of Individual or group to be contacted)

Located at _____

(Address, City, State, Zip)

Phone _____

I,_____, born on ____/_____/____

(Print Patient Name)

hereby authorize Amy Horne, Ph.D, to disclose/obtain (circle one or both) the following information from clinical records:

____	Entire record	____	Diagnosis and dates of treatment
____	Summary of treatment	____	Psychological Evaluation
____	History and background	____	HIV status, if relevant
____	Complete Treatment records	____	Substance abuse history
____	Other:_____		

For the following purpose:_____.

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

_____ _____

Print patient name Date

_____ _____

Patient signature Date

_____ _____

Print Parent or Guardian, if patient is a minor Date

_____ _____

Parent or Guardian signature, if patient is a minor Date