`

Robert M. DuWors, Ph. D.
Clinical Psychology and Neuropsychology
162 Hegeman Ave, Suite 106
Colchester, VT 05446
Telephone: (802) 876-7613
Fax: (802) 876-7813

Patient's Name: _____ DOB: _____

( ) I hereby authorize Dr. Robert DuWors to release the following information to:

Name: _____

Address: _____

( ) I hereby authorize Dr. Robert DuWors to request the following information from:

Name: _____

Address: _____

____ Mental Health Related
____ Alcohol/ Substance Abuse Related

Specific Information:

___ Treatment Summary
___ Psychological Testing Report
___ Diagnostic /Intake Assessment
___ Psychiatric Evaluation
___ Discharge Summary
___ Telephone Contact Only
___ Other: _____

My signature below acknowledges my consent to the release/ exchange of information to the aforementioned recipient party. I understand that I may revoke this consent in writing at any time. Except for where the information has already been released. Unless otherwise revoked, this authorization will automatically expire upon termination of this episode of behavior/ health treatment. The recipient of information hereby notified that any information disclosed to the recipient party pursuant to the release and request for information is protected by state and federal laws and may not be disclosed without express written authorization. I release Dr. Robert DuWors, his employees, and agents, from the release of information on such person; agency provided that said release of information is done substantially within applicable law.

_____	_____	_____
Signature of Patient/ Legal Guardian	Relationship	Date
_____	_____	_____
Witness	Title	Date