New Day Psychology LLC

Authorization For release/request of Confidential Information

+Client's Name: ____
First Name Middle Name Last Name

+Date of Birth ____ _____ _____

+Person Authorized to give permission (Your Name-adult only): ______________________

+Relationship to Client (Self/Mother/Father): _______________________________________

Person(s) authorized to speak with NDP regarding client (Psychiatrist/Physician …)

+Name: ____
Title First Last

+Address: ____

+Phone: ____

+Email: ____________________________**+ Fax:**_____________________________________

Authorization and Signature: I give permission for dr. Dor at (NDP) New Day Psychology, LLC. to communicate with +(name of physician/institute/person) _____________________________________and exchange information, regarding medical and psychological information.

I authorize the release of confidential information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law. This information will be used for evaluation, treatment, or psychological consultation regarding the client listed above. The above permission includes oral communication and exchange of relevant client information, including but not limited to, summaries of treatment, copies of records, and diagnosis, when necessary. This permission is granted for 365 days.

____ ________________
Name of Authorized Person granting Permission (you) Date

____
Signature

____ ________________
Name of Authorized Person receiving Permission (physician/ social worker..) Date

____
Signature

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