Authorization for Release of Information

I, ______________________________, expressly authorize ___________________________ to contact Dena Roberts, L.P.C., concerning my medical or psychological care and treatment.

I understand that this authorization can only be used by the parties stated. Any communication with other practitioners must be authorized by me prior to any exchange of information. I understand that all information, either written or verbal, will be kept confidential by both parties as designated by professional code of ethics.

Patient Signature____
Patient Printed Name_____________________________________
Date ____

Practitioner Signature______________________________________
Practitioner Printed Name___________________________________
Date _____________________________________