Doug Bennett, Ph.D., M.B.A.
Clinical Psychologist
3 West Main Street, Suite 202, Westerville, OH 43081 614-356-0540
www.bennettevolution.com

AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____
Name Birth date SSN

In accordance with federal confidentiality rules (42 C.F.R. part 2), I authorize Dr. Doug Bennett to:
_____release to, _____exchange with, _____receive from,

_____
Name/Title/Facility

_____
Address

_____
City/State/Zip

the following information: _____Medical information
_____Psychological test reports
_____Psychiatric/psychological data regarding diagnosis and treatment
_____Other:_____

Records and information NOT TO BE RELEASED include:_____
_____

The purpose of this request is for:
_____Insurance/third party reimbursement _____Continuity of care

_____Assistance in evaluation/treatment _____Pending legal action

_____Other (specify):_____

This authorization shall expire 60 days from the date of signing or upon termination of treatment, whichever is longer, and is subject to revocation by the patient at any time prior to the expiration date. Revocation is not retroactive to any information already released with this authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Witness Date