AUTHORIZATION FOR EXCHANGE OF MEDICAL RECORDS

The undersigned authorizes the exchange of medical records in written and/or verbal form described below concerning:

_____, birth date:_____

Between:
Andrea Bernard, Ph.D.
2011 Palomar Airport Rd., #205
Carlsbad, CA 92011
Email: dr.bernard@hushmail.com
Tel.: (760) 815-8682

And:
_____ Name

_____ Address

_____ City, State, Zip

_____ Phone Number

_____ Fax Number

TYPE OF INFORMATION

This information is limited to the following information:
___ Medical
___ Psychological
___ Academic
___ Other _____

USE OF INFORMATION

___ Treatment Planning
___ Evaluation
___ Other _____

DATE AUTHORIZATION TERMINATES

This authorization shall remain in effect for the length of treatment with Dr. Bernard, unless otherwise specified here: _____. I hereby release Andrea Bernard, Ph.D. from legal liability arising from the release of the above information. I understand that I may cancel this agreement at any time by written notice; however, I understand that information that has already been released or exchanged cannot be retrieved.

RIGHT TO RECEIVE COPY OF AUTHORIZATION

The patient has the right to receive a true copy of this authorization. By placing his/her initials on the left of this clause on the original authorization, the patient acknowledges that a true and correct copy of this authorization has been received.

Client or legal representative signature

Printed name of signatory Date