Laura Tripet Dodge LLC

Laura Tripet Dodge, MS, *Licensed Psychologist*

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Release of Information

Name: _____ Date of birth: _____

Address: _____ Phone: _____

I hereby authorize Laura Tripet Dodge, LLC. or its representative to: ☐ Release To ☐ Receive From ☐ Exchange With

Name: _____

Address: _____ Phone: _____

the information below:

NATURE OF INFORMATION REQUESTED:

☐ Statement of Diagnosis
☐ Psychological Test Results
☐ Client History
☐ Phone Consultation / Verbal Consultation or Summary
☐ Treatment Summary
☐ Psychiatric Evaluation / Medication Records
☐ Results of Chemical Assessment
☐ Physical Evaluation / Laboratory Data
☐ Other _____
(Please specify)

PURPOSE OF REQUEST FOR INFORMATION:

☐ Assessment and Diagnosis
☐ Treatment Planning
☐ Coordination of Treatment Delivered by Separate Agencies and/or Other Individuals
☐ Other _____
(Please specify)

I understand that no other use will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purposes stated above. I understand that I may revoke this consent at any time and that, in any event, it expires automatically as described below. This consent expires within one year of this date or when the purposes for which it was generated have been accomplished, whichever occurs first.

_____ _____
(Signature of client) *(Date of signature)*

_____
(Signature of parent / legal guardian / witness if the client is a minor or incompetent)