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DISCLOSURE AUTHORIZATION FORM

Please sign the statement below giving your permission for me to communicate with individuals or agencies on your behalf.

I (your name) ______________________________

hereby give consent to David F. Dahl, Ph.D. to release or receive any information deemed necessary to or from

(name of individual or providing agency) ______________________________

(address) ______________________________

(phone) ______________________________

(fax) ______________________________

which is relevant to the purpose stated below, from the case records of:

(name of patient) ______________________________

Your relationship to the patient (circle one) self spouse parent child personal representative

for the purpose of: (circle one)

☐ Evaluation

☐ Treatment

☐ Other: ______________________________

This authorization is valid for ☐ one year ☐ until revoked by me ☐ indefinite.

Authorization and signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature: ____________________ Personal representative: ____________________

Print name: ____________________ Personal representative: ____________________

Signature: ____________________ Personal representative: ____________________

Print name: ____________________ Personal representative: ____________________

Date: ____________________