Denise L. Newman, Ph.D.
Clinical Psychologist
Adults, Children, and Parent-Infant Mental Health

Contact:
Phone: (504) 482-1412
Fax: (504) 482-2615
Email: Dr.Newman@me.com

Mailing address:
4616 South Carrollton Avenue
New Orleans, LA 70119

Request for Release of Confidential Health Information

Patient name: _____ Date of birth: _____

When you complete and sign this form, it authorizes this psychologist to release protected information from your own (or your child's) clinical records to the person or agency below, or to obtain information from this person or agency. You have the right to revoke this authorization, in writing, at any time by sending notification of this revocation to my office address.

I _____ , give permission to Dr. Newman (and/or her staff) to disclose or obtain the following information in regard to the above-named or the above-named minor's psychological/medical/psychiatric/psychoeducational treatment or evaluation. The particular information to be disclosed/obtained is the following (please be specific):

_____

_____

This authorization will remain in effect until: _____

The information should be disclosed to/obtained from the following (please provide full addresses and telephone numbers):

Name of agency or provider(s): _____

Address: _____

Telephone: _____ Fax: _____

I understand the statements above, and I voluntarily consent to disclosing/obtaining this information to/from the person or agency named above. I release from any liability that could arise from disclosing or obtaining this information as long as the information is disclosed or obtained in accordance with applicable laws.

Print name: _____ Today's date: _____

Signature: _____ Relationship to patient: _____

Signature of the child/adolescent (if appropriate): _____