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

Contact:
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Mailing address:
4616 South Carrollton Avenue
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Patient name: _____ **Date of birth:** _____

Request for Release of Confidential Health Information

When you complete and sign this form, it authorizes Dr. Newman to release protected information from your own (or your minor child's) clinical records to the person or agency you list below ***or*** for Dr. Newman 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 confidential health information in regard to the above-named person (or a minor child) for purposes of psychological/psychiatric/educational and medical treatment or evaluation, and to assure the best standard of care. In particular, the information to be shared is for the purpose of ____ medical continuity of care and other purpose described:

_____

_____

This authorization will remain in effect from: _____ to: _____

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

Name of person, agency or healthcare provider: _____

Full Address: _____

Telephone: _____ EHR/Fax: _____

I understand the statements above and hereby voluntarily consent to Dr. Newman disclosing or obtaining this information from the person or agency named above in support of my healthcare needs. I release Dr. Newman 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 your name: _____ Today's date: _____

Signature: _____ Relationship to patient: _____

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

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