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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize David Blackmon, Ph.D. to: (**Check all that apply**)

_____ Exchange _____ Obtain and/or _____ Release all information pertaining to the medical, psychiatric, psychological, and/or educational evaluation and treatment of

_____
Patient Name (printed) Patient Date of Birth

To/From: _____
Name

_____
Address

_____
City/St/Zip

_____
Phone Fax

A signed revocation may be signed at any time.

I hereby release David Blackmon, Ph.D. from any legal liability which may arise as a result of the use of this released information.

This information has been disclosed to you from confidential records. Any further disclosure is strictly prohibited unless the client provides written consent.

_____ _____
Signature of Patient (or legal Guardian) Today's Date

_____ _____
Signature of Witness Today's Date

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