Samuel Blumberg, Ph.D. 2300 Pennsylvania Avenue, Suite 4D Wilmington, DE 19806 302-652-7733

Release of Information

Client Name: _____ **Birthdate**: _____

I authorize Samuel Blumberg, Ph.D. to ___ Release information to: ___ Obtain information from:

Name of Person or Organization: _____
Address/Phone/Fax of Person/Organization: _____

Initial next to information that may be disclosed/released:

___ Any and all records
___ Any and all records except _____
___ Consultation Reports
___ Discharge summary
___ Drug/Alcohol evaluations
___ Educational records and academic testing
___ History/Physical examination
___ Laboratory Reports
___ Medical reports
___ Medication
___ Ongoing communication
___ Psychotherapy Notes
___ Psychological Evaluations/Testing results
___ Psychiatric Evaluations
___ Psychiatry/psychology notes
___ Therapy Reports
___ Speech ___ OT ___ PT
___ Other: _____ _____

Date(s) of service: _____

This information is being released for the following purpose: _____

- I understand that this consent is valid and in effect for sixty days unless I choose to revoke it. After this date, no information can be released until a new release of information is completed.
- I understand the nature and use of the material to be released.
- I understand that I only give my authorization for the release of the records and/or information specified above, and only with the person or organization listed above, and only for the purpose(s) indicated above.
- I understand that I can revoke this consent in writing at any time. This will prevent additional information from being disclosed, but cannot change that information may have been released prior to my revoking consent.
- I understand that I may refuse to sign this consent.
- I understand that under most circumstance I may inspect and have a copy of the information described in this release. There may be a cost for this copy or other services.
- I understand that if the recipient of the information released above is not a healthcare provider who is subject to federal privacy regulations, the privacy of this information is not guaranteed and it can potentially be redisclosed.
- My signature indicates my understanding of the above statements.

_____ _____ _____ _____
Signature of client or personal representative | Date | Witness | Date

_____ _____
Printed name of client or personal representative | Relationship to client

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REVOKING OF CONSENT

As of this date, _____, I hereby provide written note to revoke the above consent.

_____ _____
Signature of client or personal representative | Date