Gary Friedman, Ph.D.
Liberty Place,
313 W Liberty Street,
Suite 228
Lancaster, PA. 17603

Release of Information

Permission is given to _____

To release to or obtain information from Gary Friedman, Ph.D. regarding

_____
(Name of Client) (Date of Birth)

The information released or obtained will be for the purpose of diagnostic assessment and treatment planning.

I authorize the request/disclosure of my information as described below:

☐ Psychiatric/Psychological Evaluation and Treatment Summaries
☐ School Records, Testing Results, and/or School Performance
☐ Abstract of Medical Records (verbal & written communication, medication history including allergies, updates)
☐ Legal Communications
☐ Verbal Communications

Dates:_____

I understand that the information in my health care record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

I understand that once the information is released, we are no longer accountable for its use. I further understand that my consent to release information will expire in one (1) year unless I withdraw my consent in writing, and that withdrawing my consent will not apply to information that has already been released.

_____ _____
Client Signature and Date Parent/Legal Guardian Signature and Date

_____
Client's Name (Please Print)

_____ _____
Witness Signature Date