RON WYNNE, PhD, ABPP
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AUTHORIZATION TO EXCHANGE INFORMATION FORM

Client Name _____ DOB _____

Address _____

I, _____,
Client Name (or name/contact information of Client's Legal Custodian)

authorize Ron Wynne, PhD, ABPP and ***(names/phone numbers):***

_____

_____

to exchange the following written and/or verbal information about my treatment and/or assessment ***(please check all that apply):***

- ☐ Notification of beginning and/or ending of treatment
- ☐ Periodic summary of treatment progress
- ☐ Coordination of service agreement/treatment planning
- ☐ Educational information/records
- ☐ Past Treatment
- ☐ Intake assessment Summary
- ☐ Psychological Evaluation
- ☐ Financial information
- ☐ Discharge Summary
- ☐ Current psychiatric diagnosis
- ☐ List of current psychotropic medications and dosages
- ☐ Other (specify): _____

The purpose of the disclosure authorized herein is to ***(specific purpose of the disclosure):***

_____

_____

_____

This information release consent is given freely, voluntarily, and without coercion, and may be withdrawn by me at any time. Any information I authorize others to release to Dr.Wynne will be held strictly confidential and will not be released without my written permission except as permitted by State or Federal law. I have the right to inspect the record or mental health information on the above-named individual. ***This authorization is effective for one year from the date below.***

_____ _____

Signature of Client (or Client's Legal custodian) ***Today's Date***