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Release of Information Form

I _____, Birth date _____ give permission for Heather Hopper, Ph.D. or her assigned representative to exchange information about me with the following person(s) and or entity(ies):

Information to be exchanged (initial all that apply):

All information required for continuity of care with the professional listed above, including

Verbal consultation All written clinical records

The following written clinical records only: _____

Without this permission, there may be a lack of continuity of care, resulting in limitations to the treatment I receive.

The following information _____ in order to fulfill the

following request: _____.

Without this permission, the information I request released will not be released.

This release form will expire 90 days after the last date of treatment or one year after the date signed, whichever is lesser. I understand that I may revoke this release of information at any time by writing a statement to this effect, signing, dating it, and providing it to Heather Hopper, Ph.D.

Printed Name

Signature

Date