Jennifer Roberts, Ph.D.
Licensed Psychologist (CO #3726)
19 Old Town Square, Suite 238
Fort Collins, CO 80524
(646)526-3116

Authorization to Release/Request Information

____ ________________

Client's First Middle Last Names Client's Date of Birth

Hereby authorizes Dr. Roberts to exchange information with and collect information from :

Name of Person, School, Hospital, Agency:

____

Street Address:____

____

Phone Number: ____

Specific Information to be exchanged: _______________________________________

____

Purpose of information exchange: ____

____

I understand and voluntarily agree to authorize the exchange of information. I understand my consent can be revoked at any time and will expire in one year from the date of my signature. I understand that this consent may include disclosure of alcohol and drug abuse records protected by federal regulation.

____ ____________

Signature of Client or Responsible Party Date

____ ____________

Signature of Witness Date