____authorizes discussion and/or exchange of

documents between William Thorbecke Ph.D. and:

____
Person and Agency Represented (if applicable)

____
Address and Phone Number

Purpose of Information: Psychiatric and Mental Health Treatment Planning and Continuity of Care

[ ] Information about past and/or current treatment
[ ] Physicians Orders
[ ] Financial
[ ] Admission Summary
[ ] Personal
[ ] Psychological Testing
[ ] Consultation
[ ] Discharge Summary
[ ] Other(Specify)
[ ] School Performance

CLIENT- Please INITIAL the following items if you authorize an exchange of information:
[ ] Yes Alcohol and Drug Treatment information (Specifically protected under law)
[ ] Yes AIDS/HIV/other STD testing information (Specifically protected under law)

I understand that my records are protected under the federal and state confidentiality regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (such as probation, parole, etc.).

Signature of Client_______________________________________ Date____________________

Client's Birthdate____ SS #____________________

Signature of Witness______________________________________ Date____________________

Signature of Parent, Guardian. or Legal
Representative ____ Date____________________
(Specify Relationship to Client)

To Be Renewed: Yes [ ]; No [ ]