

Release of Information Consent

I, _____, authorize _____ to:

(send) (receive) the following (to) (from) the following agencies or people:

Name: David N. Lombard

Address: 3242 Mallard Cove Lane

City: Fort Wayne State: IN Zip: 46804

Academic testing results

Psychological testing results

Behavior programs

Service plans

Case notes

Summary reports

Intelligence testing results

Vocational testing results

Medical reports

Entire record

Personality profiles

Also includes substance abuse/alcohol abuse records, HIV/STD status and legal records

Psychological reports

Progress reports

The above information will be used for the following purposes:

Planning appropriate treatment or program

Continuing appropriate treatment or program

Determining eligibility for benefits or program

Case review

Updating files

Other (specify) Forensic evaluation to assist attorney

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule. I have been informed what information will be given, its purpose, and who will receive the information. I understand there may be negative consequences as a result of releasing this information and I agree to hold harmless Dr. David Lombard and Dr. Tamara Lombard and agree not to seek legal or board actions against them.

Client's signature: _____ Date: ____/____/____

Parent/guardian signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Person informing client of rights: _____ Date: ____/____/____

Mail To: David N Lombard, PhD 3242 Mallard Cove Lane Fort Wayne, Indiana 46804