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Authorization Consenting to Release of Information

I authorize Dr. Philip Keddy to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person(s) or staff of clinic, agency, or institution(s) named below **and** to receive any relevant information from them.

1. _____
(Name)

_____
(Address)

_____

_____
(Phone, fax, e-mail)

For the following reason(s):

(i)___ Consultation/Psychotherapy (ii) ___ Evaluation (iii) ___ Other

If "Other" reason, please specify _____

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to the conditions outlined in the Statement of Privacy Practices and the Office Policies forms.

_____
(Please print name) (Date) (Signature)

Revised 11/11/04