AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

PATIENT NAME_____ DOB:_____

I give Dominique Tardif, LMT permission to release or exchange information with:

NAME: _____

AGENCY: _____

ADDRESS: _____

PHONE NUMBER: _____

Information to be Released or Exchanged:

_____ History

_____ Case Notes

_____ Other (specify) _____

_____ _____

Patient/Responsible Party Date