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Release of Information Form

I _________________________________ give permission for Heather Hopper, Ph.D. or her assigned representative to exchange information about me with the following person(s) and or entity(ies):

____

____

Information to be exchanged (initial all that apply):

___ All information required for continuity of care with the professional listed above, including
___ Verbal consultation ___ All written clinical records
___ The following written clinical records only: ____
Without this permission, there may be a lack of continuity of care, resulting in limitations to the treatment I receive.

___ The following information ____ in order to fulfill the

following request: ____.
Without this permission, the information I request released will not be released.

This release form will expire 90 days after the last date of treatment or one year after the date signed, whichever is lesser. I understand that I may revoke this release of information at any time by writing a statement to this effect, signing, dating it, and providing it to Heather Hopper, Ph.D.

____
Printed Name Signature Date

____
Witness Printed Name Signature Date