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Name:

Spouse/Partner's Name:

I/We,_____, authorize

Julie Bindeman, Psy-D to exchange, verbally and/or in writing, the checked information listed below with:

For the Following Purpose(s):

____Demographic Information ____Intake Assessment/Psychosocial History

____Psychological Evaluation ____Pertinent Psychological Testing Results

____Diagnosis ____ Treatment Plan or Summary

____Participation in Treatment ____Progress in Treatment

____Treatment Update _____Discharge/Transfer Summary

____Other_____

I/We understand that I/We have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time, except to the extent that action has been taken, by informing the above named individual in writing. I further understand that this authorization is valid only for the period of one year from the date of my signature below.

_____ _____
Signature Date

_____ _____
Signature Date