Leonard J. Sommer, Ph.D.

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient's Name _____

Date of Birth_____/_____/_____

Address _____

Person(s) to be contacted: _____

Address: _____

_____

Telephone:

I hereby authorize Dr. Leonard Sommer to communicate with _____

regarding my care.

I understand that portions of my medical record or school record may (1) pertain to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse; (2) relate to venereal disease; (3) contain information acquired by social workers consulting me in their professional capacity; (4) contain communications between myself and psychotherapists relative to the diagnosis or treatment of my mental or emotional condition; (5) contain confidential communications with a sexual assault counselor; or (6) contain results of HIV testing. I hereby release Leonard J. Sommer, Ph.D. from any liability in connection with such disclosures.

Signature of Patient (or Guardian) _____

Date _____