

Cynthia A. Bailey, Ph.D.
Clinical Neuropsychology

ITO: _____ RE: _____

_____ DOB: _____

I authorize you to release information from the records of the above named patient to:

Cynthia A. Bailey, Ph.D.
51 Wallace Avenue
Sarasota FL 34237

I understand that I am waiving the privilege provided to me under Florida and federal law and that the release of such information may pertain to the diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism and drug addiction that I may have experienced and that may be recorded in said records or information.

I, the undersigned, understand that I may revoke this consent at any time except to the extent they action has already been taken in reliance on it and that if not revoked earlier, this consent shall expire 90 days after the date on this consent unless another date is specified.

Specification of the date, event or condition upon which the consent expires:

Prohibition on Disclosure: This information being disclosed is from records the confidentiality of which is protected by Florida and federal law. Those regulations prohibiting further disclosure of this information not described herein except with the specific written consent of the person to whom it pertains or the person authorized to give consent.

Signature of Patient Date

Signature of Responsible Party Name of Responsible Party (Print)

Relationship to Patient