JOSEPH DOHERTY, Ed.D.
Licensed Psychologist
MA License 3649
N.P.I. 1215099718

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION AND RECORDS

Patient's Name: _____

Address: _____

_____

Date of Birth: _____

_____ 1. I hereby request and authorize Dr. Joseph Doherty to release any and all confidential records about me obtained in the course of diagnosis and/or treatment to:

_____

_____

_____ 2. I hereby request and authorize the following professional or agency to release any and all confidential information or psychological records about me to Dr. Joseph Doherty, Ed.D.

_____

_____

I have carefully read and understood the above statements and do herein expressly and voluntarily consent to disclosure of the above information to the person or agency named above. I further release Dr. Joseph Doherty, Ed.D. from any liability arising from the release of information to such person or agency, provided the said release of information is done substantially in accordance with applicable law.

I understand that this authorization is subject to revocation, in writing, unless action based on it has already been completed.

Date : _____ Patient: _____

Print Name: _____

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