Dr. Brad S. Broeder
Clinical & Forensic Psychologist
Florida & NYS Licensed

#1266 First Street *(941) – 953 – 6804*
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , on this date, _____ , do hereby grant permission to Dr. B. Broeder, to receive, share, dispense, discuss, acquire, obtain, review, and/or consult with any, and all designated parties listed or described below, or their designated associate(s), for the professional purpose(s) of sharing and/orcompiling any and all information as to me or my child(ren)'s situation that Dr. Broeder believes to be meaningful and/or significant. The expressed purpose of this 'release-of-information' form, is to gather, compile, collect, share, disclose, discuss and ascertain any and all, emotional, mental, educational and/or social facts, findings and documents, as well as legal, medical and/or psychological diagnoses, clinical impressions, observations, and/or diagnostic findings on behalf of myself, my child or children and spouse/partner in order to best facilitate an effective treatment plan and/or family law resolution.

I further understand that Dr. Broeder will be acting in accordance with my personal consent to obtain or dispense such information. I also understand that by sharing, disclosing, dispensing, consulting, collecting, reviewing and/or discussing such information that Dr. Broeder is conducting his professional practice in a manner with me, my family and/or my child(ren)'s, best interests in mind, or in response to the courts designated interest in my case and the welfare of me and my family. Such information is gathered to serve said interests such that he can best evaluate, treat, assist, recommend or respond to me and/or my family's needs, problems or dilemma(s). By granting Dr. Broeder permission to speak on my behalf, I recognize that I am, in essence, waiving my right to privileged and private communication(s). I do so with the understanding that these communications are being conducted with my clinical goals, personal/familial interests, treatment needs or, court appointed observances in mind and, that I thereby respect Dr. Broeder's progress notes, treatment plans, therapeutic goal(s) and/or evaluative questions, techniques, conclusions and recommendations, as being of sound professional standards, consistent with APA, (American Psychological Association) guidelines.

By completing the attached page I acknowledge that I am providing my written permission and *CONSENT* for Dr. Broeder to make such overtures on my behalf. Therefore, by completing the following section I further understand that I am waving my rights under the HIPPA guidelines as I grant consent to Dr. B. Broeder.

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Patient's Name: _____. Date: _____.

Address: _____. Age: _____.

Phone Numbers: (H)_____; (C)_____; (W)_____.

Date of Birth:_____. Profession/Occupation/School:_____.

Family Member(s), DOB & Age(s): _____

_____.

Purpose(s) of Information Being Released/Shared: _____

_____.

DESIGNATED PARTY(s) to Share/Collect/Dispense/Receive Information & Consult:

1.) Professional Party/Associate: _____ .

Address: _____. Phone: _____.

2.) Professional Party/Associate: _____ .

Address: _____ . Phone: _____.

3.) Professional Party/Associate: _____ .

Address: _____ . Phone: _____ .

Patient's Name (Print): _____. Date: _____ .

Patient's Signature: _____.