# David P. Ehman, Ph.D.

Licensed Clinical Psychologist

**4700 Belleview, Suite L12**
**Kansas City, MO 64112**
**(ph) 816-756-1227 (fax) 816-756-1438**


## Release of Information Form

I, _____, born on _____,

hereby authorize **David P. Ehman, Ph.D., Clinical Psychologist**, to receive / exchange / or send information from / with / to:

_____

Phone: _____

Fax: _____

_____

_____

_____

**This information includes telephone discussion of treatment, appropriate records and/or prepared summaries of treatment, psychological testing or other relevant testing or clinical materials.**

**Please understand that the medical records of the person signing this form may not be disclosed or re-disclosed by anyone—including the above communications—without his or her written consent.* The consent for the information being authorized and shared here may be revoked at any time by submitting a request in writing to Dr. Ehman. This consent will expire one year from the date of this consent, unless otherwise specified: _____.**

**Consent is given on this day's date:** _____, _____.

**Signature of Patient**: _____

Guardian Signature (If needed): _____

**Witness:** _____ **Date:** _____

I give permission to have information faxed to a confidential fax. Yes No Initials _____

**PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any futher disclosure of this information except with the specific written consent of the person to**

**whom it pertains. A general authorization of release of medical records or other information held by another party is not sufficient for this purpose.**