

Carolyn Murphy, Ph.D.
PSY 17150
PO Box 355
Atascadero, CA 93423

RELEASE OF CONFIDENTIAL INFORMATION

I (name of legally responsible parent) _____ () request () authorize
_____ to disclose (type, amount, and time period of information to be
disclosed) _____

to Carolyn Murphy, Ph.D. for the purpose of _____
_____.

The designated information about my minor child () may () may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. The provider of the information and the recipient designated above () may () may not discuss by telephone the content of the information released.

This request and authorization to release information is based on my understanding of the content of my minor child's records, the use of the information once it is released, and my understanding that the sources providing the information cannot be responsible for the protection of privacy once the information is conveyed. I release the source of information from all liability arising from the release.

I understand that the recipient of the requested information is prohibited by federal law (Code of Federal Regulations 42, Part 2) from making any further disclosure without my specific written permission with the exception that the information obtained may be used in the completion of a court-ordered evaluation of my minor child.

I understand that this release of information is intended to allow me to provide my informed consent for the exception in confidentiality and the protection of my privacy as guaranteed under federal law.

This consent is subject to revocation at any time except to the extent that the disclosure has already taken place and Dr. Murphy has relied upon said disclosure in the formulation of her conclusions. If not previously revoked, this consent will revoke at the time the final report is submitted.

Legally Responsible Parent or Guardian

Date