Gabrielle Lawrence, Ph.D.
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480-607-5030 office 480-948-9054 Fax gabrl1@cox.net

I understand that Dr. Gabrielle Lawrence has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Dr. Lawrence to release some of my personal information to certain individuals or agencies.

I, _____, authorize Dr. Lawrence. to share my information with the following:

Name: _____

Function_____

Specific Office at Agency:_____

Phone Number: _____ Fax: _____

Email Address _____

Office Address: _____

_____

_____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail

☐ by e-mail ☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

I understand:

☐ That I do not have to sign a release form and that I do not have to allow Dr. Lawrence, to share my information. Signing a release form is completely voluntary. If I would like Dr. Lawrence to release information about me in the future, I will need to sign another written, time-limited release.

☐ That Dr. Lawrence and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency (Family Court) receiving my information may be required by law to share it with others.

☐ **This release expires 6 months from the date signed**

☐ **That this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.**

Print Name:_____ **Signature:**_____

Date:_____ **Time:**_____