

Dr. Cynthia Edwards-Hawver, Psy.D. and Associates, LLC.

400 South State Street
Clarks Summit, PA 18411
cynthiahawver@mac.com
www.drcynthiahawver.com
Phone: 570-575-3765
Fax: 570-587-1747

Release of Confidential Records Form

By signing this document, I _____ (patient's name)
authorize Dr. Cynthia Edwards-Hawver and Associates, LLC to release the following
information/records to the third party listed below and to receive
information/records from the third party listed below:

To The Following Third Party:

I understand that by signing this document that Dr. Cynthia Edwards-Hawver and Associates is not legally or ethically responsible in any way for how this Third Party uses the information. I also authorize this information to be shared by fax, email, mail, phone, and in person. By signing this document I am fully aware that my limits of confidentiality and reduced since communication now exists between Dr. Cynthia Edwards-Hawver and Associates, LLC and the party(s) listed above.

This release will remain in affect until _____

Therapist Working With Patient _____

Patient's Full Name (Print) _____

Patient's Date of Birth _____

Patient's Signature _____

Today's Date _____