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

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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 _____