Lindsey R Buckman, PsyD
Buckman Psychological Consultants, PLLC
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I understand that Dr. Lindsey Buckman has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Dr. Buckman to release some of my personal information to certain individuals or agencies.

I, _____, authorize Dr. Buckman to share the following specific information with:

Contact for release of information:	Name: Specific Office at Agency: Phone Number:

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.*

Information to be released:	*(List as specifically as possible, for example: name, dates of service, any documents).*
Purpose of information:	*(List as specifically as possible, for example: to receive benefits).*

I understand:

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

☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Dr. Buckman.

☐ That Dr. Buckman 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 or person getting my information may be required by law or practice to share it with others.

This release expires on _____
Date

I understand 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.

Signed:_____ **Date:**_____ **Time:**_____