Dusty L Humes, Ph.D.

2201 San Pedro NE, Bldg 4-102, Albuquerque, NM 87110 512.917.3126

CONSENT FOR DISCLOSURE OF RECORDS

Client Name: _____ Date of Birth: _____

I hereby authorize the following person or agency to release psychological and/or medical records to Dusty L Humes, Ph.D. for the purpose of treatment planning, psychological assessment and/or ongoing coordination of treatment.

Name: _____

Address: _____

Tel #: _____ Fax # _____

I also give my permission to Dr. Humes to share information from my assessment and/or treatment with the above person or agency: yes no (circle one)

I understand that this authorization will remain in place for the full period of treatment or evaluation and may be revoked in writing at any time. If I have concerns about what information may be shared, I will discuss this with Dr. Humes.

Signature_______________________________________ Date: ________________________