# Todd E. Ransford, Ph.D.
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## Authorization for Release of Information

Notice to clients: I can help you better if I am able to work with other agencies and individuals that know you and your family. By signing this form you are giving permission to these organizations and individuals to share information about your situation.

Name: _____ D.O.B. _____

I authorize Todd Ransford, Ph.D. to provide and exchange information with:

Name: _____

Address : _____ Phone: _____

Including information and records pertaining to:

□ mental health assessment and treatment
□ alcohol or drug abuse assessment and treatment
□ family history
□ employment/unemployment
□ academic or educational functioning
□ medical assessment and treatment

other as listed: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: do not release.

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate treatment services for me and my family, unless otherwise specified below.
□ other purpose: _____

This authorization is valid for 180 days from the date that I signed it. I can revoke this authorization at any time, but understand that the withdrawal of authorization will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have a right to receive a copy of this form upon request.

□ client
□ parent
□ legal guardian

_____ (signature) _____ (date)

_____ (witness) _____ (date)

To those receiving information under this authorization: this information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.