DONNA R. B. ROGERS, Ph.D.
Licensed Psychologist
1140 Holly Springs Road, Suite 207, Holly Springs, NC 27540 Phone: (919) 802-0312

RELEASE OF INFORMATION

I, _____ give my permission to release and/or
(Patient, Parent, or Guardian)

exchange medical and/or psychological information between Dr. Donna R. B. Rogers and:
_____
(Agency name and/ or individual to be contacted, and address and phone number)

regarding: _____
(Patient's Name)

Patient's Date of Birth _____ Patient's Social Security #: _____

I understand information to be released/exchanged is to be for treatment and evaluation purposes only.

I release Donna R. B. Rogers, Ph.D. and personnel from any legal liability resulting from the release of the above information, with the understanding that professional cautions will be taken to protect confidentiality. I also understand that I have the right to request and receive a copy of this authorization. I understand that I can revoke this consent at any time as long as it is withdrawn before contact has been made. I understand that this consent will not expire without notice given by me.

_____ _____
Patient/Guardian Date Witness Date