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Consent to Release Privileged Information and Records

To each person or entity receiving a copy of this disclosure agreement, I request that you exchange and release all of my records and history as described below to the office of Cognitive Forensic Alliance, PLLC, or to my attorney, at my discretion, and that you do so without restriction or qualification. I understand that the release of information from professional persons/facilities requires my consent. I retain the right to limit, withdraw, or revoke this release at any time. I understand that, except for the purposes of this forensic examination, providing evidence, or testimony, and providing continuing education and research, this release will remain in full force and effect until it is revoked in writing or until all appeal deadlines have passed. This release also includes all similar records as related to any minor child(ren) for whom I am legal guardian.

NAME OF EXAMINEE/PATIENT:	DATE OF BIRTH:
DATES OF INTEREST FOR RELEVANT RECORDS:	EXAMINEE/PATIENT SOCIAL SECURITY #:

INFORMATION IS REQUESTED FROM (PROVIDER):	Release to: Cognitive Forensic Alliance, PLLC Michael Decker, LPC Alissa Sherry, Ph.D. Email Documents To: MDECKER@COGNITIVEFA.COM
STREET ADDRESS:	
CITY, STATE, ZIP:	
FAX: PHONE:	
EMAIL ADDRESS:	
INFORMATION TO RELEASE:	

PURPOSE FOR DISCLOSURE: The information being disclosed is intended for use in a forensic examination for the court, or in the anticipation of litigation, that may result in a written or oral report to be provided to the court and to others. I fully understand the nature and the content of the information to be released. I take sole responsibility that the information exchanged may be detrimental and damaging to me or to my legal position. I release the examiners and release each person and each entity from any liability that might directly or indirectly result from the exchange of any information indicated in this agreement. I agree to the examiners' office policies regarding this examination. Unless noted otherwise below, a photocopy or fax of this form and my signature is as valid as the original. I understand, agree, and specifically authorize that this disclosure release also includes the disclosure of any record that may contain information relating to assessment of, testing, diagnosis, or treatment for AIDS, HIV, sexually transmitted diseases, employment records, legal records, educational records, mental disorders, and for drug, alcohol, or other substance use or misuse. I hereby consent to the release of any and all records, as well as consent to any verbal communication with Cognitive Forensic Alliance, PLLC, by the above named individual/organization:

SIGNATURE: _____ PRINTED NAME: _____DATE: _____