Dr. Robin Tucker Lapidus, LLC
776 Farmington Avenue
West Hartford, CT 06119
860-490-6531
rtlapidus@gmail.com

Authorization to Release and/or Obtain Information

Name _____D.O.B _____

I hereby authorize Dr. Robin Tucker Lapidus to communicate with the following person/agency regarding confidential information that might be useful in treatment planning:

Name/Organization: _____
Relationship to Patient: _____
Address: _____
Telephone Number: _____

I understand that the information to be released and/or obtained is to be used solely for the purpose of treatment planning. This consent is valid until the end of treatment, and it may be voided at any time by my request.

_____ _____
Signature Date