DAVID W. WERNER, PSY. D.
339 Washington St., Suite 203
Dedham, MA 02026
781-329-1159

RELEASE OF INFORMATION
COURT EVALUATION

I agree to release all medical, psychiatric, drug and alcohol, and legal records for the purpose of psychological evaluation to David W. Werner Psy. D. In addition I give Dr. Werner permission to speak with all hospital and/or therapeutic staff concerning my treatment and behavior if hospitalized. I authorize Dr. Werner to interview any person he deems necessary to reach an opinion about my case. I understand that all information gathered through these records or interviews with Dr. Werner will be used in his evaluation and that this evaluation may be submitted to a court of law for review. I also give Dr. Werner permission to speak with my attorney(s)_____. This release of information will be in effect for 180 days following the date noted _____.

_____ _____
Signed (patient) date

_____
Printed name

_____ _____
Witness date

_____
Guardian (if necessary)