Jennifer McMillan, LMFT, LMHP

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RELEASE OF INFORMATION

I,_____, authorize Jennifer McMillan, LMFT/LMHP to exchange with, obtain from and/or provide information to:

Name:_____
Clinic/Agency:_____
School:_____
Address:_____
Phone:_____Fax:_____

Any or all of the following information: records, evaluations, recommendations, treatment plans, progress of treatment or, other (specify):

_____

Regarding Client:_____DOB:_____

The purpose of this is to aid in the evaluation, treatment, coordination of services and/or other activities (specify):

Information to be released:

___Psychological history
___Psychological evaluation
___Diagnosis
___Treatment plan
___Medical information
___School records
___Substance abuse history
___Other

I understand that I may revoke this release at any time by submitting a written request but that such a request will not apply to any information exchanged prior to the date of such a request being received. I specifically authorize the release of drug and alcohol information.

_____ _____
Signed Date

_____
If signed as parent or guardian, state relationship

_____ _____
Witness Date