Margaret Reedy, Ph.D.
Clinical Psychology
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AUTHORIZATION TO RELEASE INFORMATION

Client Names: _____

_____

This consent authorizes Margaret Reedy, Ph.D. to release to/obtain from and/or exchange information concerning the above-named individual(s) regarding:

_____ Psychological/psychiatric history, assessment, diagnosis, treatment

_____ Medical history or treatment

_____ Academic or educational information, records, testing or history

_____ Psychological testing results or reports

_____ Psychiatric hospitalization records

_____ Legal information or records

with the individual and/or organization listed below:

Name of individual and/or organization: _____

_____

Address: _____

_____

Telephone: _____

This information is to be used to help establish an appropriate treatment plan for the above named individual(s) and/or to help coordinate other treatment and/or services to the individual(s) named above.

Signed: _____ Date: _____

Signed: _____ Date: _____