JOHN MCCONNELL, PH.D.
PSYCHOLOGY LICENSE PSY 10673

Release of Information

I, _____, born on _____
(name of patient or patient's parent/guardian))

hereby give permission to Dr. McConnell to communicate about

__ myself __ my ward (if applicable, please include name & DOB):

with the following individual, agency, or insurance company on my behalf:

_____
(name of individual, agency, company to be contacted

_____
(address, city, state, zip of said individual, agency, company)

_____
(phone/fax)

I also hereby also authorize

_____to communicate with Dr. McConnell on my behalf.
(name of other doctor, agency, or insurance company))

I authorize the exchange of the following information and clinical records:

__ Diagnosis and dates of treatment __ Summary of treatment
__ Psychological evaluation/assessment __ All treatment records

__ Any Information necessary for billing, including treatment reports and records

__ Other (please specify):

for the following purpose:

I understand the released records may contain information about alcohol use, drug use, nicotine use, HIV status, AIDS status, STDs, and other medical information.

This authorization and request to disclose or obtain information from my records will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

Patient Name or Guardian's Name _____

Patient or Guardian's Signature _____ Date _____

Relationship to patient:

__ self __ guardian __ parent of a minor

__ person legally authorized to act on the behalf of the patient

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