METROPOLITAN
PSYCHOLOGICAL ASSOCIATES, P.C.

Consent for Release or Exchange of Confidential Information

Name of Client:_____

Date of Birth:_____

I hereby authorize the release and exchange of information between ***Jeremy Novak Ph.D., LP*** and the following individual, agency, or institution:

Name:_____
Address:_____
Phone: Fax:_____

This is a reciprocal release.

This authority extends to the furnishing of copies of all or any desired portion of the records pertaining to the above-named client. This exchange is for the purpose of ***Treatment planning and coordination***. This authorization expires upon completion of treatment or as noted:_____.

The client has a right to retain a copy of this release. The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this consent at any time by informing all of the above parties in writing. A photocopy or electronic copy is as valid as the original. This is a strictly confidential patient medical record.

Redisclosure or transfer is expressly prohibited by law.

_____
Client Signature Date

_____
Parent or Guardian Signature Date

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