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AUTHORIZATION TO RELEASE INFORMATION

I, _____, THE UNDERSIGNED, GIVE PERMISSION TO JENEV CADDELL, PSYD of My Best Relationship Psychological Services, PLLC, TO

RELEASE/EXCHANGE THE FOLLOWING INFORMATION:

□ MY DIAGNOSIS
□MY LENGTH IN TREATMENT
□ MY ATTENDANCE IN THERAPY
□ MY TREATMENT PLAN
□ INFORMATION RELEVANT TO COORDINATION OF CARE
□ OTHER:

TO/WITH:

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

THIS RELEASE WILL BE VALID FOR A PERIOD OF ONE YEAR UNLESS OTHERWISE NOTED.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. IN CONSIDERATION OF THIS CONSENT, I HEREBY RELEASE THE ABOVE PARTIES FROM ANY LEGAL LIABILITY RESULTING FROM THE RELEASE OF THIS INFORMATION.

_____

SIGNATURE DATE