JENNIFER ROBERTSON, Psy.D.
LICENSED PSYCHOLOGIST

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CONSENT TO RELEASE & EXCHANGE INFORMATION FOR CLINICAL SERVICES

I want the following confidential information about me to be exchanged:

__ Psychological/Psychiatric Assessment Information
___ Psychological/Psychiatric Treatment Records
___ Synopsis of Psychological/Psychiatric Treatment
___ Psychological/Psychiatric Diagnosis
___ Educational Records/Files
___ Medical Assessment Information
___ Medical Treatment Records
___ Synopsis of Medical Treatment
___ Medical Diagnosis
___ Other _____

I want this information exchanged between Dr. Robertson and the following service provider or agency:

___Therapist/Physician/Organization_____

Phone Number(s) _____

Expiration & Terms*: I understand that this consent is good until one year from the date of my signature below, and that it encompasses consent to release information from before the signature date as well as additional information received after this consent is signed. In addition, I understand that information may be shared in writing, via email, in computerized form, and/or in meetings or by telephone.*
Review: *I understand that I have the right to review and amend my health record under the conditions and with the exceptions outlined in detail in the Informed Consent and the Notice of Privacy Practice forms. A copy f this consent to release information will be placed in my file.*
Revocation*: I understand that I can withdraw this consent at any time. The revocation will not apply to information that has already been released. I must revoke this consent in writing to Dr. Robertson. This will stop the listed parties from sharing information after they know my consent has been withdrawn.*

I understand that by signing this two-way consent to release information, I am freely giving my permission for the two parties indicated above to discuss information provided by me to either party, and any other pertinent clinical or historical information, as it pertains to the continuity of my treatment and safety.

_____ _____
Client Name Date of Birth

_____ _____
Signature of Client Date of Signature

_____ _____
Signature of Witness: Jennifer Robertson, Psy.D. Date of Signature