CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: ____

Client's Date of Birth: ____

I hereby consent to and authorize

Name: ____

Address: ____

____

Phone: ____

to release information to Jana Scrivani, Psy.D. concerning the above named client's psychiatric, psychological, medical, and educational evaluations and treatments. Furthermore, I hereby consent to and authorize the release of information from Jana Scrivani, Psy.D. to the above named person. Such information may be disclosed in writing, via email, or orally.

Duration: This authorization shall become effective immediately and shall remain in effect for the duration of one (1) year from today.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that was already made, in reliance on this authorization, before the time you revoke it. Your revocation must be made in writing.

Signed: ________________________________ Date: _____________

Print name: ________________________________