Jennifer M. Politis, Ph.D., LPC, LLC

LICENSED PROFESSIONAL COUNSELOR

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CONSENT FOR RELEASE OF INFORMATION

Date: _____

I hereby authorize Jennifer M. Politis, Ph.D., LPC located at the above address to release information from the records of _____ _____.

Patient's Name (please print) Date of Birth

The information should be released to _____

Teacher and/or School

_____

(Address or Department)

Purpose of this communication ("At request of individual") _____

_____.

The information to be released is (Itemize the portion of records & the time period) _____

_____

I understand that this consent will expire upon my termination of treatment with Dr. Politis.

I have the right to change my mind regarding the release of information from my clinical record at any time, unless such information has already been released. The undersigned understands the nature of the authorization and has informed that she/he has the right to revoke the consent at any time, by written communication with Dr. Politis.

Dated this _____ day of _____, 2012

_____ _____

Patient Parent/legal Guardian/Authorized Representative

_____ _____

School Representative Signature Date

NOTE to recipient of this information: This information has been disclosed to you from records whose confidentiality Is protected by Federal & State Law whose regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. Anyone who receives information covered by these regulations, whether obtained legally or not, is prohibited from using that information for any criminal or civil investigation, or prosecution of the patient.