Authorization Release of Information Jason Prendergast, PhD(c), LPC

This form allows me to communicate with other professionals about your treatment progress.

_____ _____
Client Name Client Date of Birth

This form authorizes Dr. Jason Prendergast, LPC to

_____ Release information to:
_____ Request information from:

_____ _____
Name Phone Number

_____
Address

Information released/requested to include:

_____ Dates and types of service
_____ Diagnosis
_____ Treatment goals and therapeutic progress

This protected health information is being used or disclosed for the following purposes:

_____

_____

This release shall be in force and in effect for 180 days from date of signature unless otherwise requested in writing.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_____ _____
Client Signature Date