



710 E. Grand River  
Brighton, MI 48116  
(810) 225-1670 Fax (810) 225-1675

### Consent for Release or Exchange of Confidential Information

Name of Client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize the release and exchange of information between my therapist, **Jeremy Novak Ph.D., LP** and the following individual, agency, or institution:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Fax: \_\_\_\_\_

This is a reciprocal release.

This authority extends to the furnishing of copies of all or any desired portion of the records pertaining to the above-named client. This exchange is for the purpose of **Treatment planning and coordination** and expires one year from the date signed unless otherwise specified.

The client has a right to retain a copy of this release. The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this consent at any time by informing all of the above parties in writing. A photocopy or electronic copy is as valid as the original. This is a strictly confidential patient medical record.

Redisclosure or transfer is expressly prohibited by law.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent or Guardian Signature Date