



Consent for Release or Exchange of Confidential Information

Name of Client: _____

Date of Birth: _____

I hereby authorize the release and exchange of information between **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