

Steven D. Nichols, Ph.D.
LICENSED PSYCHOLOGIST
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PATIENT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes me to release protected mental health information from your clinical record to the person(s) you designate below. In order to provide the best quality care to my patients, I request permission to discuss your (or your minor child's) treatment with other health-care providers/agencies that have had past or present involvement with you. Signing this authorization enables me to exchange clinical information with your primary care physician, past/current therapists, psychiatrist, case workers, or others named below in order to coordinate treatment, care, and follow-up.

I, _____, hereby give my consent to Steven D. Nichols, Ph.D. (address above) and to the clinicians or agencies named below to exchange any information related to my (or my minor child's) medical, educational, or mental health history in order to coordinate treatment, care, and follow-up. I understand that I may cancel this consent to the extent that information has already been exchanged; otherwise, this consent will expire one year from the last date of my (or my minor child's) treatment with Dr. Nichols.

1. Name _____

Address _____

Phone _____

3. Name _____

Address _____

Phone _____

2. Name _____

Address _____

Phone _____

4. Name _____

Address _____

Phone _____

Signature of Patient or Legal Guardian

Date

Signature of Witness

Date

Please sign below ONLY if you choose not to sign above.

I, _____, decline consent to have information exchanged between my (or my minor child's) primary care physician (or others) and Dr. Nichols. I understand that such exchange may benefit the coordination of treatment. I further understand that treatment with Dr. Nichols is not contingent on this consent. I hereby decline consent.

Signature of Patient or Legal Guardian

Date

Signature of Witness

Date