Jessica D. Getson, LPC, DBTC
555 Andorra Glen Court, Suite 2
Lafayette Hill, PA 19444
Phone: 610-828-2802
Fax: 610-828-2829
Jessica@jessicagetson.com

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Date: _____

I, (client) _____ permit Jessica Getson to obtain and/or release my:

_____ Progress Notes
_____ Treatment Summaries
_____ Psychological Evaluations
_____ Other (as specified here) _____

from and/or to:
Provider/Agency Name _____

Provider/Agency Address _____

_____

Provider/Agency Telephone_____

for the purpose of:
_____ Facilitating Treatment
_____ Other (as specified here) _____

This authorization will expire one year from the above date, unless specifically stated to the contrary, below:

_____

By signing below, I understand that I may revoke this authorization at any time except after the above material has been obtained or released pursuant to my prior authorization.

Client or Guardian: _____ Date: _____

Witness: _____ Date: _____