Jessica D. Getson, LPC, DBTC
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Jessica@jessicagetson.com

# AUTHORIZATION TO OBTAIN AND/OR RELEASE HEALTHCARE INFORMATION

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

_____Treatment Summaries
_____ Other (specify) _____

from and/or to:

Provider/Agency Name _____

Provider/Agency Address _____

Provider/Agency Telephone_____

Provider/Agency Email _____

for the purpose of:

_____Facilitating Treatment
_____Other (as specified here) _____

This authorization will be in effect while I am under the care of both providers 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: _____