

Jessica D. Getson, LPC, DBTC
Positive Therapy for Personal Healing

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 or typing name 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 Signature (type name if submitting electronically): _____

Date: _____