Jessica D. Getson, LPC, C-DBT
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 Responsible Party Signature (type name if submitting electronically) Date