MARK C. PURCELL, PSY.D.
LICENSED PSYCHOLOGIST

Release of Confidential Records Agreement

Date:

I, _____, am authorizing the release of confidentiality for pertaining to psychotherapy records and information for the purposes and time period outlined below.

Scope of Treatment: This document authorizes the release of confidential psychotherapy records and information related to treatment with the following professionals:

Professional: _____

Organization: _____

Address: _____

_____

Phone: _____

E-Mail: _____

Duration: This release of confidentiality covers the dates: _____ to _____.

Purpose: The purpose of releasing confidentiality is for the coordination of services between service providers. I understand that confidential information will not be related to other family members in treatment unless authorized by myself.

Right to Revoke Release: I understand that I may revoke this release of confidentiality at any time for any reason.

Signed Authorization: _____

(If client is a minor, signature of parent or custodial guardian)

Minor's Name & Signature (optional): _____

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