Fulton Psychological Group

Margeaux Duclos, MA LMFT 135960

Authorization to Release Information

Patient: _____

Address:_____

I hereby authorize Margeaux Duclos, M.A.. to disclose and/or receive from

_____

(name) (phone #)

information pertaining to my (or my child's) psychological services rendered from:

_____ to _____.

Specific information requested includes: _____

_____

This authorization is good until: _____

This authorization allows Ms. Duclos to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Ms. Duclos signature: _____ Date: _____