

Staci Elkins, MA AMFT133915

Supervisor: Christopher Fulton, Ph.D., PSY 14741

Authorization to Release Information

Patient: _____

Address: _____

I hereby authorize Staci Elkins, 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 Staci Elkins to discuss information described above and can be canceled at any time in writing by the patient.

Signature: _____ Date: _____

(parent, if patient is a minor)

Staci Elkins' signature: _____ Date: _____