Joseph C. Mallet, Psy.D.,P.A.
Pediatric ◆ Adolescent ◆ Family Psychology

Release of Information

Name of Patient _____ **DOB** _____

Authorization is hereby granted to Joseph C. Mallet, Psy.D. to secure and release psychological, medical, educational and other relevant confidential information pertaining to treatment of the above named patient. I acknowledge that Dr. Joseph C. Mallet, Psy.D. has discussed the content and meaning of this Release in a manner in which I understand. The duration of this Release of Information is for _____days/months. I also understand that this Release can be withdrawn at any time for any reason. Should I decide to discontinue this Release, I will personally notify Dr. Joseph C. Mallet, Psy.D. of my decision to do so. Information may be exchanged orally or in writing and may also include medical/psychological records/psychological testing or any other information pertaining to treatment.

The signature on this Release is provided without duress and is acted upon by my own free will.

Authorization granted to:

Name of Person(s):_____

Relation to Patient: _____

Purpose of Release:_____

_____
Printed Name of Patient

_____
Signature of Parent/Guardian (required if patient is a minor)

_____ _____
Witness Signature Date

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