Lisa K. Willis, Ph.D., CGP

Licensed Clinical Psychologist
(585) 454-9448

CONSENT TO RELEASE INFORMATION

My signature below authorizes my therapist, _____, to communicate with my current primary care/specialist healthcare provider(s) listed regarding general concerns about my past, present, or future physical or emotional state in order to coordinate treatment for my benefit

_____
Health provider's name and address

_____
Health provider's name and address

My signature below authorizes contact between my therapist, _____, and the individuals or agencies listed below. I authorize my therapist to communicate with the following individuals or agencies regarding general concerns about my past, present, or future physical or emotional state, treatment given, and billing information. I have listed below any specific restrictions on the types of information to be released.

_____
Individual or Agency's name and address
_____ No additional restrictions _____ Billing/financial information only

Other restrictions: _____

_____
Individual or Agency's name and address
_____ No additional restrictions _____ Billing/financial information only

Other restrictions: _____

_____ _____
Signature Date

_____
Print name

You have the right to revoke this authorization, in writing, at any time by sending such written notification to your therapist's office address. However, your revocation will not be effective to the extent that he or she has taken action in reliance on the authorization.

Revised 10/2011

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