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AUTHORIZATION AND RELEASE OF INFORMATION

I ___________________________________ Authorize Dr. Dayna Nelson Psy.D. to release information/speak to the following regarding:

Name:____DOB:_________________

TO:
Name:____
School/Organization:____
Address____
Phone________________________________Fax___________________________________

_______Please release the following information to Dr. Dayna Nelson:

______Case Consultation by telephone
______Medical Consultation
______Medical/Mental Health Records or Reports__________________________________

_______________________________________ _________________________
Signature of Patient or Parent/Guardian Date

____ __________________________
Dayna Nelson Psy.D. Date