Mind Works
Consulting and Psychological Services

Release of Information Form

Jennifer Sweeton, Psy.D., Clinical Psychologist
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650.450.7904

I _____, do hereby authorize Jennifer Sweeton, Psy.D. to release
(Patient's Name)
diagnostic and treatment information, consultation information, records, and professional opinion to the following person and/or agency:

Name	Address	City	Zip	Phone

I do hereby release Jennifer Sweeton, Psy.D. from any and all liability and any and all claims of any nature whatsoever pertaining to the disclosure of this information in the above named patient. A copy of this form shall be regarded in the same manner as the original. It is further understood that I may revoke this authorization at any time only by written request, except to the extent that action has been taken in reliance thereon. In any event, this consent expires automatically one (1) year from the execution date noted below.

I understand that my records are protected under the federal and state confidentiality laws and cannot be released without my written consent unless otherwise provided for in the law. The information I authorize for release may include information regarding diseases which may be considered communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS), and may include information about drugs, alcohol, and sickle cell anemia. This language is included as required by 63 O.S. statute 1-502.2. Billing and payment history may also be released. I acknowledge that the information to be released was fully explained to me, and this consent if given of my own free will.

_____ _____
Signature Date

_____ _____
Witness Date