Jane Brown, Psy.D.
Kathryn Robb, Psy.D.
Jane Brown Evaluations, INC.
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Release of Medical/Mental Health Information

Client name: **DOB**:

If client is a minor, name of **parent or guardian** completing this form:

I authorize Dr. Brown and Dr. Robb to release and receive information about myself or my child for the purposes of the current evaluation, consultation, or treatment.

If there are any restrictions on the information shared between Dr. Brown and the professionals below, please explain here:

Name of school, physician, teacher, or person to contact	please include both **email** and **phone** number for each person listed

This authorization may be relied upon when transmitted by facsimile:

Yes		No	

I further authorize the medical records to be sent by facsimile:

Yes		No	

I agree to hold Provider harmless if any information by facsimile does not reach the appropriate authorized recipient:

I understand that this consent is revocable except to the extent that action has been taken in reliance thereon and this consent shall remain in force for one year or until date:

Signature: Date: