Megan Pollock Therapy

Caring support through life's transitions, challenges, & demands

Confidential Release of Information

I hereby authorize Megan Pollock to release and receive to:

Name | Title/Organization

Address | City | State | Zip Code

Phone Number | Fax Number

Email Address

information regarding services received for the purpose of:

treatment coordination

Client Name

Address | City | State | Zip Code

Phone Number | Email Address

This release is in effect until one year past the date of last session and/or written correspondence with Megan Pollock. I understand that I may revoke this form at any time by notifying, in writing, the people, departments, or offices authorized by this form to release information. Ms. Pollock will be able to acknowledge the revocation at that time to the authorized parties if necessary.

Signature _____ Guardian (if Participant is under 18) _____

Printed Name _____ Printed Name _____

Date _____ Date _____

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