**Stacey J Nelson Ph.D.**

1200 N. Federal Highway Suite #200

Boca Raton FL 33432

(561) 859-7779 [drstacey@peoplepc.com](mailto:drstacey@peoplepc.com)

**ALL CORRESPONDENCE**

P.O. BOX 7052, DELRAY BEACH FL 33482

**MUTUAL EXCHANGE OF INFORMATION**

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION BY PSYCHOTHERAPIST**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize disclosure and communication

Written or verbal, including internet email, and telephone answering machines and voicemail, of medical,

Psychological, or psychotherapeutic information regarding myself and/or minor child and to obtain the same

type of information for the purpose of assessment, diagnosis, treatment planning, psychotherapeutic

management, psychotherapy, referral or consultation, between my psychotherapist Stacey J Nelson Ph.D.

and the following named individuals or organizations:

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Other specified purposes of release of confidential information:

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I have been informed of the nature of this consent and I understand and agree that the purpose of each

disclosure will be to provide the best possible therapeutic care.

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CLIENT (or parent of a minor) DATE AND TIME

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STACEY J NELSON Ph.D. LMFT DATE AND TIME