Sean Flynn, Ph.D., P.C.

Psychologist

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MEDICAL RECORDS RELEASE

PLEASE CHECK THE APPROPRIATE BOXES AND SIGN AND DATE BELOW

☐ I hereby authorize _____to release copies of medical and psychiatric records of patient (name) _____ to Sean Flynn Ph. D. and or his associates at the above address.

☐ I hereby authorize (Providers Name) _____ to communicate with and exchange information about patient (name) _____ with Sean Flynn Ph. D. and or his associates.

☐ I hereby authorize Sean Flynn, Ph. D. to release copies of medical and psychiatric records of patient (name) _____ to _____.

☐ I further release any further information in these records referring to any history of substance abuse, any history of child or elder abuse and/or neglect, the patient's HIV or AIDS status or any other medical conditions, any history of the patient's endangering themselves or others, and/or any history of criminal activity alleged or committed by the patient.

The purpose of this release is for:

☐ Continuing Care

☐ Change of provider of care

☐ Other: _____

_____

_____ _____

Patient/Parent/Legal Guardian Signature **Date**

_____ _____

Witnessed by **Date**

This release of information shall expire in one year from this date.