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NEUROFEEDBACK FOR HEALTH

Release of Information

I, _____, give Joelle Jacobson permission to release and/or receive information from the following parties:

_____
Name Phone Relationship to Client

_____
Name Phone Relationship to Client

_____
Name Phone Relationship to Client

I understand that the exchange of information will remain confidential between mentioned parties and is for the purpose of treatment of_____.

Client Information:

_____
Name

_____
Address

_____
Telephone Number Fax Number

_____
Client Name (printed) Date

_____
Client Name (signature) Date

_____
Joelle Jacobson (signature) Date