



Phone: (630) 217-9911
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Naperville, IL 60564
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Authorization for Release of Information

Patient Name: _____ DOB: ____ / ____ / ____

Address _____

Phone Number: (____) _____

I, _____

(Patient/Guardian Name)

authorize _____ Psychology911 _____ to

disclose to _____

(Name, Address, Phone/Fax Number)

The following specific information from my records: _____

I understand that this release will expire one year from date signed. I may withdraw this consent by giving written notification to the Psychology911 at any time. I understand that I cannot withdraw consent retroactively for information exchanges that have already occurred.

Patient Signature: _____ Date: ____ / ____ / ____