Whitney McMullan Therapy
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, (full name) _____, hereby authorize Whitney M. McMullan, LCSW and the associates of Whitney McMullan Therapy (or the covering therapist) to exchange with any of the following individuals and entities, any confidential information contained in any mental health, medical, or substance abuse records which they may have regarding me (full name) _____.

The purpose of such disclosures is to facilitate Whitney and her associates the ability to assess and treat me and to provide continuity of care. I may revoke part or all of this consent at any time.

Spouse/Partner/Parent(s): (full name and phone)

_____

Therapist: (full name and phone)

_____

Psychiatrist: (full name and phone)

_____

Primary Doctor/Pediatrician: (full name and phone)

_____

Nutritionist: (full name and phone)

_____

Other significant individuals in my life: (full name and phone)

_____

Signed:

_____Date:_____