*Megan Nolan Ph.D.*

*411 Chinn Street, Suite 3, Santa Rosa, Ca.95404*

*707-691-3957 PSY11513*

**Authorization of Consent to Release of Information**

I authorize Dr. Megan Nolan to **discuss**, verbally or in writing, anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following reason(s):

\_\_\_\_ Consultation/Psychotherapy,

\_\_\_\_ Evaluation,

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies (Form #1).

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Name (print) Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name (print) Date Signature