Psychological Services, LLC
Ebony Dennis, PsyD

I _____ (patient's name) hereby authorize the release and/or exchange of information, between Ebony Dennis, PsyD,_____ and the people listed below. The purpose of this request is consultation and feedback. This authorization will begin on _____and expire on _____ or when I specify. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider. I understand that treatment may not be denied if I refuse to sign this authorization.

_____ _____

Name Date

Please list the names of people with whom Dr. Dennis_____ , is authorized to share information. You may add more names if necessary.

_____ _____

Name/relationship to patient Phone number

_____ _____

Name/relationship to patient Phone number

_____ _____

Name/relationship to patient Phone number