Seattle
Psychologists, P.S.

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Carolyn N. Roll, PhD
Clinical Psychologist
Joseph R. Mills, PhD
Clinical Psychologist

Release of Information

This consent is valid for 90 days from the date of signature, and is subject to revocation by the client or client's parent/guardian at any time. Any action taken before revocation is excused.

Name of Client:_____

Date of Birth:_____SSN:_____

For the purposes of continuity of care, professional consultation, medication, diagnosis, treatment planning, or other related communication, I hereby authorize an exchange of information between my psychologist (check one)**,**

_____**Dr Joseph R. Mills, and:** _____**Dr Carolyn N. Roll, and:**

Person/Organization:_____

Address/Phone: _____

_____

_____Information to be exchanged is ***unlimited***.

_____Information to be exchanged is ***limited to the following checked items***:

_____psychological/psychiatric
_____medical
_____educational
_____other (*specify*):_____
_____intake assessment/evaluation
_____treatment plan
_____termination summary

_____This consent to release information is ***two-way***, allowing for a mutual exchange of information between my psychologist and the person or organization named above.

_____This consent to release information is ***one-way***, from my psychologist to the person or organization named above.

_____This consent to release information is ***one-way***, from the person or organization named above to my psychologist.

I hereby release Dr Roll and Dr Mills and Seattle Psychologists, PS from all legal responsibility or liability that may arise from the release of information and/ or records.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Clinical Psychologist Date