Joelle Jacobson, M.A., M.F.T., P.P.S.
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Release of Information

I, ___________________________, give Joelle Jacobson, M.A., M.F.T., P.P.S., permission to release and/or receive information from the following parties:

____
Name | Relationship to Patient

____
Name | Relationship to Patient

____
Name | Relationship to Patient

I understand that the exchange of information will remain confidential between mentioned parties and is for the purpose of treatment of___________________________.

Contact Information:

____
Name | Relationship to Patient

____
Address

____
Telephone Number | Fax Number

____
Name | Relationship to Patient

____
Address

____
Telephone Number | Fax Number

____
Patient Name (printed) | Date

____
Patient Name (signature) | Date

____
Joelle Jacobson, M.A., M.F.T., P.P.S. | Date