Joelle Jacobson, M.A., M.F.T., P.P.S.
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Release of Information
(for minor)

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

Name of 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 for _____ (Name of Patient).

Contact Information:

_____
Name Relationship to Patient

_____
Address

_____
Telephone Number Fax Number

_____
Guardian Name (printed) Date

_____
Guardian Name (signature) Date

_____
Guardian Name (printed) Date

_____
Guardian Name (signature) Date

_____

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