Release of Information

I/We, _____ (Print Legibly Please) give Matt Sughrue, MS, LMFT, LCMFT permission to discuss my/our case with the following person or organization named below;

Name, Address and Telephone Number of person or organization

_____
_____

By signing this release I/we permit you to exchange any clinical information including case notes, tests, charts, exams and treatment plans. The purpose of this exchange of information is to maintain continuity of care for the client or patient.

Signed:_____ Date:_____

Signature of client or patient

Signed:_____ Date:_____

Signature of client or patient

Form 12092015