dr. Jessica E. Wilson
LICENSED CLINICAL PSYCHOLOGIST
Phone: 503-476-1910 | Fax: 503-894-6019 | E-mail: jessica.wilson.psyd@gmail.com

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____ Date of Birth: _____

I, the undersigned, hereby consent to, direct and authorize Jessica E. Wilson, Psy.D. to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Jessica Wilson and/or to the following person or agency:

_____ at _____

Name Fax Number

The information or records to be released or disclosed include:

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Other (specify):

_____

_____

_____ Any and all records/Information

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I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Jessica Wilson and her staff from any and all liability arising from release and disclosure of the information and records to the above named person.

I understand that I have a right to revoke this authorization at any time by sending written notification or directly contacting Dr. Jessica Wilson. Unless sooner revoked or otherwise specified, this authorization expires sixty (60) days after the date written below.

_____ _____

Client Signature Date

_____ _____

Signature of Parent, Guardian, or Authorized Representative (if required) Expiration Date (Optional)

Witnessed by:

_____ _____

Jessica E. Wilson, Psy.D. Date