Julie Behrens, Psy.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________________ ______________

give consent for

____
Name

____
Address

____
Address

____
City, state, zip code

____
Phone number

to exchange information about my medical, social and/or psychiatric history, status and/or treatment with Julie Behrens, Psy. D as it pertains to services I am requesting/receiving from Dr. Behrens. I hereby authorize the written or spoken exchange of past or present records, test data, summaries, opinions and or other information including, but not limited to, the following: behavioral health (including psychiatric, psychological, legal and/or alcohol- or other substance-related) diagnoses, status, condition, and/or treatment.

My signature below conveys my authorization for this exchange of information. This authorization is valid for 90 days from the date of signature. If authorization is to be revoked prior to 90 days, such revocation must be in writing and will not pertain to information already exchanged in reliance on this authorization and prior to revocation.

______________________________________ ______________
Name (signature) Date