Craig Jones, Psy.D.
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Release of Information

I give my consent for Craig Jones, Psy.D. to contact the following named clinicians/institutions regarding ________________________ (Date of Birth: ___________).

Please provide the name of the contact, the name of the institution's, the telephone number and, if possible, the fax number.

Name: ____

Location/Address: ____

Telephone Number: ____

Fax Number: ____

I give permission for Dr Jones to:

___ Obtain **and** share information

___ Release Report (if explicitly requested)

___ Other (please specify limits desired):

____

In understand that this release expires 180 days from the date below. I also understand that this releases Craig Jones, Psy.D. from any and all legal responsibility and liability that may arise from the act I have authorized in this release.

____
Patient or Parent/Guardian Signature

____
Date

____
Printed Name

____
Relationship to Client