Teresa Bailey, Ph.D., Inc.
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Release of Information

I hereby authorize Teresa Bailey, Ph.D., Ph.D, to release to and/or obtain all pertinent information about treatment and/or assessment & evaluation.

_____(Initial) This release of information shall include but not be limited to mental health, substance, and/or alcohol use, concerning:

(PATIENT'S/CLIENT'S NAME:)_____

Date of Birth: _____/_____/_____
mo. day year

the following person(s) and/or institution(s):

(NAME OF INDIVIDUAL, PROFESSIONAL, OR INSTITUTION to be contacted by Dr. Bailey)

Name: _____

Address _____

_____

Phone/Fax _____

This release remains in effect for one year from the date of signing unless revoked in writing by the undersigned. NOTE: Voicemail or Email is NOT considered written notification for the purposes of granting or revoking permission to communicate.

_____Signature of patient/client or legal representative

_____ Print name

_____ Patient or client's name if a minor

_____ Date