MATTHEW J. SULLIVAN, Ph.D.
Clinical Psychology
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Authorization for Release of Medical/Confidential Information

Client's Name ____________________________Birthdate________

I, ________________________and/or_________________________
name name

Authorize ____
Releasing Agency Telephone #

____
Address

To exchange information/records with:

Matthew J. Sullivan, Ph.D.
417 Tasso St.
Palo Alto, CA 94301 (650) 326-2004

The following information, with the knowledge that such contact discloses my services. The disclosure of records is required for evaluation, treatment planning or for the following purpose:

____
____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon, and if not earlier revoked, this consent expires on _____________

Signed ____________________ _______________
Client/Parent/Guardian Date

____________________ _________________
Client/Parent/Guardian Date