

Mary Ann Nugent, Psy.D.
Clinical Psychologist
PSY 22644

949-300-2337

Authorization to obtain release or exchange records

To: _____

Address: _____

Phone #: _____ Fax: _____

Re: _____ Date of Birth: _____

I hereby authorize Mary Ann Nugent, Psy.D., to obtain, release, and exchange records and/or information concerning:

- medical treatment, inpatient or outpatient
- psychotherapy, outpatient (all records)
- family counseling
- school progress, individual assessment
- employment history, personnel records
- legal action or consultation
- any letter(s) which the client first approves for dispersal to a third party concerning his/her treatment.
- Phone conversation or summary of records will suffice, if preferred.

Response Preferred: Phone Conversation Preferred: Yes No Records Requested At This Time: Yes No

For this individual for the purpose of _____

This release takes effect immediately and will automatically terminate on _____

unless revoked by me earlier. If I choose to revoke this release, I understand that the

cancellation will take effect on the date written notification is received in therapist office. I

understand that information used or disclosed in accordance with this authorization

may no longer be protected by federal law and could be used or re-disclosed by the receiving party.

Date: _____ Signature: _____

Witness: _____ Date: _____