Jennifer E. Day, Psy.D., PLLC
Licensed Clinical Psychologist

4165 Westport Road, Suite 303
Louisville, KY 40207

www.drjenniferday.com

502-509-3082 telephone
502-209-7698 fax

Consent to Release/Obtain Confidential Records and/or Information

I hereby authorize **Jennifer E. Day, Psy.D., PLLC** to release/obtain information form confidential records concerning:

Client Name:_____ Date of Birth:_____

This information may be Released To/Obtained From:

_____
Name of Person or Agency

_____
Address of Person or Agency

_____
Phone Fax

The purposes of this exchange of information are:

☐ Further Mental Health Evaluation, Treatment, or Care

☐ Treatment Planning

☐ Other: _____

The following types of information may be shared:

☐ Treatment Updates/Treatment Planning

☐ Psychological Evaluation Results

☐ Progress Notes

☐ Intake & Discharge Summaries

☐ Developmental/Social History

☐ Other:_____

I have had explained to me and fully understand this consent to release records and/or information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may withdraw this consent at any time by notifying a representative of Jennifer E. Day, Psy.D., PLLC in writing. I acknowledge that nay action already taken based upon this consent cannot be rescinded. This consent expires one year from the date of signature.

_____ _____
Signature of Client or Guardian Date

_____ _____
Printed Name of Client Relationship to Client

_____ _____
Signature of Witness Date