Jean S. Gearon, Ph.D.
Licensed Clinical Psychologist
PSY1000223

Consent to Release Information

The undersigned individual agrees to allow the care provider designated below to release and exchange relevant information obtained through treatment and/or evaluation to Dr. Jean S. Gearon.

Client information

_____ _____
Name of client (print) Date of Birth

_____ _____
Signature of client Date

Provider information

_____
Name (print)

_____
Relationship/Agency (print)

_____ _____
Address Phone #

_____