MATTHEW J. SULLIVAN, Ph.D.
Clinical Psychology
Fax # (650) 813-9771 417 Tasso St. Palo Alto, CA 94301
Ca Lic# psy10214 (650) 326-2004

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