Jesse D. Matthews, Psy.D.

Licensed Psychologist

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AUTHORIZATION TO RELEASE AND TO REQUEST CONFIDENTIAL INFORMATION

Re: _____ Date of Birth: _____

Address: _____

_____

_____

This is to authorize: _____

_____

_____

To release or obtain the following information from: **Jesse D. Matthews, Psy.D.**

____ Psychiatric evaluation

____ Psychological evaluation

____ Educational records

____ Medical information

_____ Other treatment records

_____ Legal information

_____ Admission/Discharge

____ Other: _____

_____

This release shall remain in effect for one year subsequent to its signing or until rescinded in writing.

Date: _____ Signature: _____

Witness: _____