Mark G. McConville, Ph.D.
Clinical Psychologist

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Belvoir Place, Ste. 210
21403 Chagrin Boulevard
Beachwood, Ohio 44122
(216) 751-1007

markmcconville1@mac.com

Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person of facility: ____

Address: ____

To release information from records concerning ______________________________

Date of Birth ________________; Social Security Number _____________________

To the following person or facility: _______________________________________

Address: ____

For the purpose of: ____

These records concern the time between _______________ and _______________

The information to be disclosed includes the following: _____________________

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I have had explained to me and fully understand this request/authorization to release records and 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 take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

___________________________	________________________	_________
Signature of Client	Printed Name	Date

___________________________	________________________	_________
Signature of Parent/Guardian	Printed Name	Date