MEGAN POLLOCK THERAPY
Caring support through life's transitions, challenges, & demands

CONFIDENTIAL RELEASE OF INFORMATION

I hereby authorize Megan Pollock to release and receive to:

Name | Title/Organization

Address | City | State | Zip Code

Phone Number | Fax Number | Email

information regarding services received for the purpose of:

Client Name

Address | City | State | Zip Code

Phone Number | Email Address

This release is in effect until one year past the date of last session and/or written correspondence with Megan Pollock. I understand that I may revoke this form at any time by notifying, in writing, the people, departments, or offices authorized by this form to release information. Ms. Pollock will be able to acknowledge the revocation at that time to the authorized parties if necessary.

_____ _____

Signature | Date

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