Kristine Hutchison, PhD, LLC
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

Consent for Release of Medical/Clinical Information

I, _____ _____ hereby authorize Kristine Hutchison, PhD, LLC,
(Print name) (DOB)

to disclose the following information from my clinical record:

_____ participation in therapy
_____ treatment goals
_____ prognosis
_____ diagnosis
_____ progress
_____ all of the above

Information will be released to the following person(s) or organization(s):

_____
(Name)

_____
(Address) (City) (State) (Zip)

_____ _____
(Phone) (Fax)

This consent is valid for 1 year from the signature date. Consent is subject to my revocation at any time except to the extent an action has already been taken.

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date

The information, which is being disclosed, is from records whose confidentiality is protected by Federal Law. Federal Regulations (42-CRF Part 2) prohibit disclosure without the specific concern of the person to whom it pertains. A general authorization is not sufficient for such release.