RELEASE OF INFORMATION FORM

Jennifer Finlayson-Fife, Ph.D.
Licensed Psychotherapist
Winnetka, IL 60093

I, ____, the undersigned, hereby authorize Dr. Jennifer Finlayson-Fife, to provide information to and receive information from (relevant to my psychological treatment) the following entity/entities:

Name:__________________________________ Relationship _________________________

Address:____

Fax: (______)________-_______________ Phone Number (______) _______-____________

Name:___________________________________Relationship ________________________

Address:____

Fax: (______)________-_______________ Phone Number (______) _______-____________

Name:____________________________________Relationship ________________________

Address:____

Fax: (______)________-_______________ Phone Number (______) _______-____________

I acknowledge that the authorization is hereby granted voluntarily and that this release is valid for one year. I further understand that I may cancel or revoke this authorization at any time in writing.

Name (Last, First, Middle): ____

Address:____

Date of Birth (mm/dd/yy):______/______/______

Signature _____________________________________ Date: _________________________