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AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Dr. Hartman unless I request otherwise. I may withdraw this consent at any time. If withdrawn, I understand that Dr. Hartman may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also agree to pay any fees, if applicable, associated with copying, reviewing, and mailing of records.

Complete this section to permit Dr. Hartman to consult with other providers, if applicable.

I, _____, hereby authorize Dr. Julie Hartman to communicate to the following individuals regarding my or my child's _____ medical or psychological condition.

Name/Telephone Number (i.e. physician, child's teacher or school principal/counselor, therapist):

Complete this section to allow other providers to consult with Dr. Hartman, if applicable.

I, _____, hereby authorize the following individuals to communicate to Dr. Julie Hartman regarding my or my child's _____ medical or psychological condition.

Name/Telephone Number (i.e. physician, my child's teacher or school principal/counselor, therapist):

Signature: _____ Date: _____

Printed Name: _____