**LOGAN PERSONS JONES, PSY.D.**

Licensed Clinical Psychologist

34 W 22nd Street, 2B, New York, NY 10010

646.798.8354

**RELEASE OF INFORMATION FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Logan Persons Jones, Psy.D. and Persons Psychology, PLLC to:

 \_\_\_\_release to:

 \_\_\_\_obtain from:

 \_\_\_\_exchange with:

 Name of Individual or Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Individual or Office’s Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Individual or Office’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the following information pertaining to myself:

 \_\_\_\_Contact with Logan Persons Jones, Psy.D. and Persons Psychology, PLLC \_\_\_\_Dates of treatment attendance

 \_\_\_\_Information from and results of a Psychiatric Evaluation

 \_\_\_\_Diagnosis

 \_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand the information is to be used for purposes of:

 \_\_\_\_Contact with referral source

 \_\_\_\_Continuity of care with another health care provider

 \_\_\_\_Workplace considerations or accommodations

 \_\_\_\_Academic considerations or accommodations

 \_\_\_\_Contact with family

 \_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*As the person signing this consent form, I understand that I am giving my permission to Logan Persons Jones, Psy.D. and Persons Psychology, PLLC for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to Logan Persons Jones, Psy.D. I acknowledge that a copy of this consent and a notation concerning the persons, offices, or agencies to which disclosure was made shall be included with my health care records.*

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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