STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY.D.

Release of Information:

Pertaining to:

Name: _____

DOB: _____

Address:_____

_____

I hereby give Paul W. Frehner,Psy.D. and STILLPOINT PSYCHOLOGICAL SERVICES permission to exchange information regarding myself (or if the patient is a minor regarding my child) with the following parties:

LEVEL OF PRIVILEGE: (please initial) □ exchange_____ □ give only_____ □ receive only _____

Agency:_____

Name: _____

Address: _____

_____Phone Number: _____

Date: _____ Signature: _____

Print Name: _____

Unless revoked, this release will be in force for the length of the treatment with Dr. Paul W. Frehner, Psy.D.