Jonathan Brush Ph.D.

Licensed Psychologist

1419 Beacon Street
Suite 13
Brookline, MA 02446

617-277-4300
JBrush@JBrushPhD.com
www.JBrushPHD.com

Authorization to Release Information

Name____ **Date of Birth** _ _ / _ _ / _ _ _
Address_______________________________________
____
____

Name____ **Date of Birth** _ _ / _ _ / _ _ _
Address_______________________________________
____
____

I, ____________________________________, hereby authorize the exchange of information between:`

and

___________________________________ Jonathan Brush PhD

___________________________________ 1419 Beacon Street, Suite 13

___________________________________ Brookline, MA 02446

____

I understand why the Information Is needed and I am satisfied that the material will be considered confidential.

Portion of record to be released:

___ Medical Record

___ Psychological Test Report

___ School Record

___ Summary of contact with individual or family

___ Other (specify) ______________________________________

_________________ ____
Date Signature

Witnessed:

_________________ ____
Date Signature