John R. Lynch, Ph.D. P.C.
Licensed Clinical Psychologist
7427 Brook Road
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804-353-6700

Release of Information

In order to provide the most beneficial service, it is often necessary for us to communicate with other people or agencies. This form gives us your permission to contact the person or agency named below to release information we have regarding our contacts with you, and/or for them to release information to us regarding their contact with you. Your signature at the bottom represents a waiver of your right to confidentiality only with respect to an exchange of information between your clinician and the specified person/agency. The checks below designate the type of information to be shared and the format by which the information will be conveyed. Any other sharing of information gained during contact with you is expressly prohibited. This release is only authorized for the period of current services and expires upon termination from the counseling relationship as determined by termination. You may terminate this authorization at any time by making a written request to this clinician.

Client name: _____

Clinician name: John R. Lynch, PhD

Specific person/agency to receive and/or to release information:

_____
_____
_____
_____

Type of Information to be shared:

Please check ☑ specific information:

- ☐ Acknowledgment of counseling services
- ☐ Testing/Evaluation summary
- ☐ Discharge Summary
- ☐ Other _____
- ☐ Progress Report
- ☐ Summary of Services

Please check ☑ the format(s) of information**:**

- ☐ Facsimile transmission
- ☐ Email
- ☐ Written/Mail
- ☐ Other _____
- ☐ Telephone consultation
- ☐ Face-to-face meeting

_____ _____
Client signature **Date**

_____ _____
Clinician signature **Date**