Sheryl R. Jacobs, Ph.D., P.C.

Clinical Psychologist

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Phone: (410) 580 9045
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Coordination of Care With Primary Care Physician

I, _____, hereby give my permission to have

Sheryl R. Jacobs, Ph.D., P.C.
8 Reservoir Circle, Suite 105
Baltimore, MD 21208
Phone: 410-580-9045
Fax: 410-580-9046

Release/receive information to/from:

Primary Care Physician _____
Address _____
_____
_____
Phone: _____

RE:
Patient's Name: _____
Patient's Date of Birth : _____
Address of Patient: _____
_____
_____

The specific information to be disclosed includes dates of treatment, diagnosis, treatment plan, treatment progress, psychological evaluation, and any other information listed below.

_____

I understand that I have the right to inspect the information to be disclosed, that the refusal to consent to the release means no information will be given and this consent may be revoked at any time prior to the information being sent. This authorization is valid until

Date: _____

Signature of Patient: _____
Signature of Parent or Guardian: _____
Witness: _____
Date of Consent: _____