Jim Matto-Shepard, Ph.D. PSY15031

Authorization For Release of Information

Name_____ DOB_____

This will authorize (therapist's name)_____

To exchange with Jim Matto-Shepard, Ph.D.
1 Bodega Ave, Suite 4
Petaluma CA 94952
(707) 762-1670

_____ Diagnostic and/or treatment information
_____ Psychological test reports
_____ Medical reports/impressions
_____ Other

regarding the above-named individual.

This information will be kept confidential and used only to help with diagnostic evaluation and treatment. This consent is subject to revocation by the undersigned at any time and, if not revoked earlier, shall terminate upon the completion of treatment.

Signature_____

Date_____

Signature_____

Date_____