Carol Ummel Lindquist, Ph.D., FAClinP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
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Permission to Release Confidential Records to/From Outside Sources

To: _____
(The person who has information)

Address: _____

Phone Number: _____

Re: _____
(Yourself and/or your child)

Date of Birth: _____

Permission is hereby granted to Carol Ummel Lindquist to obtain/release and information about the above named person to/from the above named person/agency regarding

_____
(self or child)

Limitations: _____

_____
(Things you don't want me to discuss)

Signed: _____

Date: _____ Expiration Date: _____

I routinely gather information from other professionals who have worked with you unless you would prefer I did not. If you have some one you have previously seen in therapy, or another professional such as an M.D. that you would like me to communicate with or get records from, please sign and return to my office. If you want me to talk to them before our first session you may fax this release to me at the above number. Otherwise, bring this form with you and we will discuss whether there is anyone additional it would be helpful to contact. You may make extra copies of this form or get them from me.

Revised 4/00.

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