CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
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Permission to Release to, or Obtain Records from, Third Parties

To _____
(name of person or entity who has, or requires information)

Address _____
(their address, city, state zip)

Phone _____
(their phone)

Re: _____
(your name, your child's name or both)

Permission is granted to Carol Ummel Lindquist, Ph.D., to obtain (or release) any information from (or to) the above-named person or entity regarding

_____
(your name, your child's name or both)

Any limitations _____

_____
(Things you do not want Dr. Lindquist to discuss or obtain)

x_____ _____
Printed Name

_____ _____
Date Expiration date (if none, write none)

Dr. Lindquist routinely gathers information from other professionals who have worked with you unless you would prefer that she does not. If you have someone you have previously seen in therapy, or another professional such as a physician that you would like Dr. Lindquist to communicate with or from whom you would like her to obtain records, please sign this form and return to her office. If you want to her to talk to them before her first session, you may fax this form at the fax number above. Otherwise, bring this form with you and you and she can discuss whether there is anyone else additional it would be helpful to contact. You may make extra copies of this form or obtain them from Dr. Lindquist.