AMALEA K. SEELIG, PSYD
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Release of Information

Name: _____

This release of information authorizes Dr. Amalea Seelig to share information from my records with the following individual or agency:

Individual's or Agency's Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

In addition to the purpose stated below, I give permission to Dr. Amalea Seelig and the individual/agency listed above to share information with each other regarding my psychiatric, psychological, and/or medical issues.

Additional Purpose:

_____

_____

I understand that this release is valid for one year from the date listed below.

Patient's Signature: _____ Date: _____

Psychologist's Signature: _____ Date: _____