David W. McMillan, Ph.D.
2809 Wimbledon Rd.
Nashville, TN 37215
615-327-2183

AUTHORIZATION FOR RELEASE OF INFORMATION

FROM:
Agency/Individual Name: _____ Phone #: _____

Address: _____ City:_____ State: _____ Zip: _____

Fax Number: _____ Email Address: _____

THE ABOVE-NAMED INDIVIDUAL IS AUTHORIZED TO DISCLOSE THE FOLLOWING INFORMATION REGARDING:

Client Name(s): _____ Phone #: _____

Address: _____ City:_____ State: ___ Zip: _____

TO:

Dr. David McMillan
2809 Wimbledon Rd.
Nashville, TN 37215

Phone: 615-327-2183

Information to be released (Check appropriate items):
_____ Social History _____ Medical History
_____ Diagnoses/Impressions _____ Treatment Notes
_____ Psychological Testing _____ Other: _____

The purpose of this disclosure is (Check appropriate items):

_____ To assist with this individual's evaluation

_____ Other: _____

I further acknowledge that the information being released was fully explained to me and this consent is given freely.

_____ _____ _____
Signature of Client (date) Signature of Witness (date)

_____
Signature of Legally Authorized Representative If Applicable (date) (relationship to child)

If client is unable to sign give reason: _____