GLENN MCCLELLAN, PH.D
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RELEASE OF CONFIDENTIAL INFORMATION

NAME _____ DATE _____

I hereby authorize and give consent to the below parties to exchange verbal dialogue, written reports, and other information necessary regarding my case. This information may be shared during the duration of my counseling with McClellan & Associates or unless specified by a certain date noted within this release of information form. My signature below acknowledges this fact and allows confidential information to be exchanged between the following individuals:

Dr. Glenn McClellan; (doctor, teacher, therapist, etc.) _____

PHONE _____ FAX _____

This authorization and release of Confidential Information will expire _____

SIGNATURE _____ DATE _____