Sarah Newcomer Marriage and Family Therapist L.L.C
Reconnecting Columbus, LLC
614-450-2870

I _____ D.O.B. / / hereby grant my permission for Reconnecting Columbus, LLC/Sarah Newcomer, MS MFT to **Release Information to and/or Obtain information from:**

Individual/Agency/Company Name

Individual/Agency/Company Contact Information

Information to be released and/or obtained (if applicable) will include:

- Clinical Diagnosis Psychosocial Summary _____
- Drug/Alcohol Information Treatment Summary _____
- Treatment Plan Recommendations _____
- Psychological Tests _____
- Other _____

For the purpose of: Psychological Evaluation Continuity of Treatment Consultation

I understand the information disclosed may be redisclosed or distributed without the knowledge of Reconnecting Columbus, LLC/Sarah Newcomer, MS MFT In this case Reconnecting Columbus, LLC/Sarah Newcomer, MS MFT is not liable for any damages resulting from such disclosures.

I further understand I may withdraw this consent at any time; however any information shared before such withdrawal is received will not be affected.
My signature for authorization or my refusal to sign this form will not affect my eligibility to obtain treatment

_____

Printed Name Date

_____

Signature