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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize David Blackmon, Ph.D. to: **(Check all that apply)**

_____ Exchange _____ Obtain and/or _____ Release all information pertaining to the
medical, psychiatric, psychological, and/or
educational evaluation and treatment of

Patient Name (printed)

Patient Date of Birth

To/From:

Name

Address

City/St/Zip

Phone

Fax

A signed revocation may be signed at any time.

I hereby release David Blackmon, Ph.D. from any legal liability which may arise as a result of the use of this released information.

This information has been disclosed to you from confidential records. Any further disclosure is strictly prohibited unless the client provides written consent.

Signature of Patient (or legal Guardian)

Today's Date

Signature of Witness

Today's Date