



# Aspen Psychological Services

Mary Jo Jeffres, Ph.D., LLC  
Licensed Clinical Psychologist

## Release of Information:

Date: \_\_\_\_\_

Information to be released to or from:

Provider or Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Any treatment information including diagnosis and records or any treatment or examination rendered to me during the period from \_\_\_\_\_ to \_\_\_\_\_ >

Signature/Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patients DOB: \_\_\_\_\_

Witness: \_\_\_\_\_

If providing or requesting records to or from Dr. Jeffres they can be sent to:

Mary Jo Jeffres, Ph.D.

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