CONSENT TO RELEASE OF INFORMATION
TO AND FROM MARK S. JONES

I hereby authorize

Name _____

Address _____

_____

Fax _____

to disclose records and have discussions concerning

Name of Client _____

Address _____

_____

Date of Birth _____

to and from:

Mark S. Jones, DMin, LPC, LMFT, BCN
16607 Blanco Road, Suite 904
San Antonio, TX 78232
210-260-9949 Fax: 210-390-0816
mjones@sanantoniocounseling.net

This consent pertains to the following types of records and information:

____ Progress notes, including initial assessment

____ Results of testing

____ Neurofeedback treatment notes

____ EEG/QEEG data, protocols and reports

____ Communications to/from other mental health, medical or educational professionals

____ Clinical impressions

____ Other: _____

I understand that I may revoke this consent, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not revoke this consent, it will automatically expire in 90 days.

_____ _____
Date Client Signature

_____ _____
Date Signature of Parent or Guardian