SULLIVAN, NOLAN AND ASSOCIATES, P.C.

Dan Nolan, Ph.D., L.P.
Kristina Rask, Ph.D., L.P.
Sarah Jurkovic, Psy.D.
Marcia Johnson, Psy.D, ABPP-Cn

Geoff Krone, Ph.D., L.P.
Dennis Pink, M.S., Sp.A., L.L.P
Pam Schwartz, Ph.D., L.P.

I, _____(Client Name/Guardian), hereby give permission for Sullivan, Nolan and Associates, P.C., 3700 W. Liberty Rd., Ann Arbor, MI 48103, to release and obtain pertinent medical, psychological, and psychiatric information regarding:

_____

Client's Name Client's Age

To/From _____

Name of Professional or Agency

_____

Address

I further release Sullivan, Nolan and Associates and its personnel from any legal liability reulting from the release of this information with the understanding that Sullivan, Nolan and Associates personnel will exercise reasonable professional safeguards regarding this information. I further understand that this authorization is valid, unless revoked in writing, for a period of 120 days from the date below.

_____

Signature of Client or Guardian Date

_____

Address of Client or Guardian

_____

Signature of Witness Date