After completing this form please send it directly to our office (not to the Billing Service) using any of these methods:

1) FAX the info to (734) 426-0034, to the attention of your therapist

2) Scan or take a photo of the completed form and send it as an email attachment to snkmoffice@gmail.com with Attn: (Your Therapist) on the Subject line, or

3) Send by US Mail to Sullivan, Nolan & Associates PC, Attn: (Your Therapist), 8110 Jackson Rd., Suite D, Ann Arbor, MI 48103.

Thank you!

SULLIVAN, NOLAN AND ASSOCIATES, PC

Dan Nolan, PhD, LP
Mark Sullivan, PhD, LP
Pam Schwartz, PhD, LP
Marcia Johnson, PsyD, ABPP-Cn
Dennis Pink, MS, SpA, LLP

Geoff Krone, PhD, LP
Kristina Rask, PhD, LP
Sarah Jurkovic, PsyD, LP
Barb Hansen, LMSW

I, _____ (Client Name / Guardian)
hereby give permission for Sullivan, Nolan, and Associates, P.C. at 8110 Jackson Rd., Suite D., Ann Arbor, MI 48103 to release/obtain medical, psychological, and/or psychiatric information which pertains to the case of:

_____
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Address

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I further release Sullivan, Nolan, & Associates, P.C. and its personnel from any legal liability resulting from the release of this information with the understanding that Sullivan, Nolan, & Associates personnel will exercise reasonable professional safeguards regarding this information. I further understand that this authorization is valid only for a period of 120 days for the date below.

Date of Consent:_____

Signed:_____
(Client or Guardian)

Address of client or guardian:_____

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Witness:_____

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