PEGGY L. FERGUSON, PH.D.
TOWN CENTER, 116 W. 7TH, SUITE 211
STILLWATER, OK 74074
405-707-9600

RELEASES

I authorize Peggy L. Ferguson, to release to my insurance company any information requested. I understand that this consent will begin on the date this agreement is signed and will be revoked two years from completion of counseling unless otherwise specified.

I understand that my medical information may include that I have a communicable or venereal disease, which may include but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as AIDS. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____
Client Printed Name

_____
Client Signature

_____
Parent/guardian (if appropriate)

_____
Date signed

_____
Witness

I attest that I am the person whose name and photo appear on attached copies of insurance and driver's license cards.

_____
Client Signature

_____
Date Signed

Please send a copy of both sides of your insurance card.

Please send a copy of both sides of your photo driver's license.