

Lewis Psychological Services

DISCLOSURE OF LICENSURE FORM

MY SIGNATURE ON THIS FORM INDICATES THAT THE FOLLOWING INFORMATION HAS BEEN DISCLOSED TO ME:

Name of Provider: Marshall H. Lewis  
Level of Education: Master of Arts in Clinical Psychology  
Title of the Provider: Psychotherapist  
License(s) of the Provider: Licensed Clinical Psychotherapist

*“I am not authorized to practice medicine and surgery and I am not authorized to prescribe drugs. Please be advised that certain mental disorders can have medical or biological origins, and that you should consult a physician.”*

CLIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_