Monica Rowson Psychological Services

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name of Client_____

Date of Birth_____ Age_____ Grade_____

Address_____

_____

I, _____(client/parent/guardian) authorize the staff at Monica Rowson Psychological Services to receive information from and release information regarding the client to:

Name_____

Address_____

Phone_____Fax_____

For the purpose of assessment and treatment.

I understand that the information is confidential and may not be released to anyone else without my written permission. My signature indicates that I have read this form and it has been explained to me. This consent expires one year from the date of signing. I may revoke this consent prior to the one year expiry date by signing in the appropriate space below.

Name (print)_____Witness (print)_____

Signature_____Signature_____

Date_____Date_____

Date consent is revoked_____

Parent/guardian's signature_____