

CONSENT TO RELEASE INFORMATION

I, _____, consent to release information regarding my therapy and/or testing with _____ to the following individual(s):

_____.

I do not consent to release the following information (if applicable):

_____.

This authorization shall expire: _____
Date (not to exceed 6 months)

I understand that I may withdraw my consent at any time.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date