Psychological Health, Wellness, & Development, Inc.

Consent to Release Information

Client Name: _____

Date of Birth: _____

I hereby authorize the exchange of information between:

Psychological Health, Wellness, and Development, Inc.

and the agency, school, or person listed below:

_____

_____
Street Address

_____
City, State, Zip

_____
Phone/Fax

Restrictions regarding the information exchanged are listed below:

_____

_____

I understand this authorization is valid for one year from the date listed below. I understand that this information may not be released to any other persons or organizations without my permission, in writing. I understand that I may revoke this authorization at any time. A photocopy or fax of this authorization shall be considered valid.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Signature of Guardian: _____ Date: _____

Relationship to Client: _____

Therapist Signature: _____ Date: _____

Copy provided: Yes _____ No _____ Date: _____

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