CONSENT TO RELEASE INFORMATON

The law requires therapy to be kept confidential unless otherwise stated. For this reason your therapist must have your permission to consult with another helping professional that may assist in your therapy.

Your signature below authorizes your psychotherapist to contact the individual named and exchange records or pertinent information. If you have any reservations about giving permission, please discuss them with your therapist.

I, (Client name, parent, or guardian)_____ give my permission for my therapist, _____ to contact and exchange information with_____

Contact information:
Phone_____ Fax_____
Address_____

Regarding
_____
_____

_____ _____
Client's signature Date

_____ _____
Parent or guardian signature Date

_____ _____
Therapist signature Date

I understand that this consent terminates one year from _____ unless otherwise stated.

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