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Permission to Release Information

Regarding : _____:

I (we) hereby authorize and request _____

_____

to release confidential professional information, including personal, psychological, psychiatric, and medical records and opinions, resulting from my contact with them to:

_____

_____.

The specific information requested is as follows:

1._____

2._____

3._____

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing any of the above noted individuals. Further, the above consent shall expire after a period of 90 days from the date of my signature below, unless it is to be extended beyond this time frame by initialing this space:_____.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Signature:_____ Date:_____

Signature:_____ Date:_____

Witness:_____ Date:_____