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Consent to Release Information

Name _____

Address _____

Date of Birth _____

My signature at the bottom of this form authorizes information from my records (or my child's) to be shared between Don Mack, LMFT and the agency or person listed at the bottom of this form.

I give permission to Don Mack, LMFT and the agency or individual listed below to share the following information:

Psychological _____ Psychometric (Testing) _____

Educational _____ Legal _____

Medical _____ Social/Family _____

I understand that this authorization is valid for one year from the date listed below. I also understand that this information may not be released to any other person or agency without my written permission. A photocopy of this authorization shall be considered valid.

Agency or School Name _____

Individual's Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

Signature of Patient or Parent/Guardian _____ Date _____

Print Name of Patient or Parent/Guardian _____