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LICENSED CLINICAL PSYCHOLOGIST, PSY 18857
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Authorization for Release of Information

This document authorizes the exchange of confidential information concerning:

_____ _____
Name of Client Date of Birth

I hereby give permission to Craig Childress, Psy.D. to disclose information to:

Name _____

Address _____

City _____ State/Province _____ Postal Code _____

Country _____ Phone _____

Information to be disclosed:

☐ Mental health related information

☐ Other (specify): _____

The purpose of this information is for:

☐ Safety and protection

☐ Professional consultation

☐ Enable the coordination of services & continuity of care

☐ Other (specify): _____

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this consent, it will expire one (1) years after the date indicated below.

Signature of Client _____ Date _____

Witness _____ Date _____