



CONSENT FOR OBTAINING AND RELEASE OF CONFIDENTIAL INFORMATION

I _____ (Please print name & relationship to client {if not the client}) hereby authorize the staff at **INSIGHT PSYCHOLOGICAL Inc.** to:

Obtain information from ____

Release information to ____

Name: _____

Address: _____

Phone: _____

Fax: _____

For the purpose(s) of _____

Progress _____ Evaluation / Testing results _____ Diagnosis _____

I understand that I give consent concerning information, which by law may be considered confidential or privileged. I understand that the information released by this consent cannot be released to anyone else unless I give written permission.

My signature indicates that I have read this form and/or it has been explained to me in a language that I understand. This consent form expires one (1) year from the current date undersigned, unless revoked by me in writing prior to that date.

Dated _____

Signature of Client/Parent/Guardian

Signature of Counselor/Witness

CLIENT CONTACT INFO:

NAME: _____

Phone Number: _____

E-Mail: _____