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 _____

Third party information (doctor, lawyer, adjuster, etc.):
Name: _____
Address: _____
Phone: _____
Fax: _____

The purpose(s) of releasing information (include reason and/or select options below):
_____

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.

_____ _____
Print name of Client/Parent/Guardian Print name of Counselor/Witness

_____ _____
Signature of Client/Parent/Guardian Signature of Counselor/Witness

Dated _____

CLIENT CONTACT INFO:

NAME: _____ Phone Number: _____

E-Mail: _____