Release of Information

This consent is valid for 90 days from the date of signature, and is subject to revocation by the client or client's parent/guardian at any time. Any action taken before revocation is excused.

Name of Client: _____

Date of Birth: _____

For the purposes of continuity of care, professional consultation, medication, diagnosis, treatment planning, or other related communication, I hereby authorize an exchange of information between my psychologist, Savana Howe, Psy.D.

Person/Organization: _____

Address/Phone: _____

_____

_____

_____ Information to be exchanged is ***unlimited.***

_____ Information to be exchanged is ***limited to the following checked items:***

___ psychological/psychiatric ___ intake assessment/evaluation

___ medical ___treatment plan

___educational ___ termination summary

___other (specify): _____

_____ This consent to release information is ***two-way,*** allowing for a mutual exchange of information between my psychologist and the person or organization named above.

_____ This consent to release information is ***one-way,*** from my psychologist to the person or organization named above.

_____ This consent to release information is ***one-way,*** from the person or organization named above to my psychologist.

I hereby release Savana Howe, Psy.D. from all legal responsibility or liability that may arise from the release of information and/ or records.

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

Clinical Psychologist Date