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Consent for Release of Confidential Information

I, _____, hereby authorize and request that
(Patient's Name)

_____
(Clinician's Name)

may release all confidential professional information pertaining to me (or my minor children) to: _____

_____

_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature _____ *Date* _____
(Patient)

Signature _____ *Date* _____
(Parent or Guardian)