Authorization to Release Information

Client's Name: _____ **DOB**: _____

Name of Guardian (if applicable): _____

I, _____, have been informed of, and understand my rights concerning the release of confidential information. Understanding my rights, I give permission for Dr. Cortney Weissglass and the staff of Weissglass Psychological Services, LLC to release/exchange information including but not limited to the following: Name, Age, Date of Birth, Address, Gender, Race, Legal Status, evaluation results, and Psychiatric Diagnosis.

_____

The above information may be released or exchanged in person, by phone, or in writing between Dr. Cortney Weissglass and staff at Weissglass Psychological Services, LLC and:

_____

_____

_____

This consent is valid for up to one year from the date of signing. This consent expires on

_____.

I understand that I may revoke this consent at any time. However, notification of the revocations of this release will be provided to Dr. Cortney Weissglass in writing only. I have a right to inspect and review the information that will be released under the supervision of my therapist/clinician.

_____ _____

Client's Signature* Office Staff or Doctor's Signature

_____ _____

Date Date

* The signature of a parent or legal guardian is required if the client is under 18 years of age or legally incompetent.