

Consent to Release Confidential Information

I hereby authorize and request Dr. Gary Seeman and the party or parties listed below to communicate with each other about my clinical needs and status, including the release of confidential information that may consist of personal, psychological, medical and consulting records and opinions, resulting from my contacts with him or them:

_____.

The specific information may include psychological assessment and medical information from interviews and personal tests.

I understand that I may revoke this consent at any time by informing Dr. Seeman in writing. I acknowledge that it is my responsibility to revoke this authorization with the other parties listed above. This consent shall expire after a period of one year from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom.

Client Name(s): _____ / _____
Please print your name(s)

Client Signature(s): _____ / _____ Date:

Parent/legal guardian name: _____

Parent/legal guardian signature: _____ Date:

Witness name: _____
Please print your name

Witness: _____ Date: