Authorization to Release Confidential Information

I, ____ ___________________________ ,
(Name of Client- Please Print) (Date of Birth)

authorize the ❒ verbal and/or ❒ written release and exchange of my otherwise confidential psychological, psychiatric, medical, vocational, and/or other information (as specified and/or limited below). The ticks made in the following boxes indicate (a) which party or parties have my permission to disclose information pertaining to his/her/their involvement with me, and (b) to whom that information may be disclosed:

❒ From: ❒ To: Michelle Ranson, Registered Psychologist

❒ From: ❒ To: Spouse/Partner/Family Member ____________________________________

❒ From: ❒ To: Health Care Professional (e.g., MD)__________________________________

❒ From: ❒ To: Mental Health Professional____

❒ From: ❒ To: Insurance Provider ____

❒ From: ❒ To: Lawyer ____

❒ From: ❒ To: Current Employer ____

❒ From: ❒ To: Potential Employer____

❒ From: ❒ To: School Representative____

❒ From: ❒ To: Ecclesiastical Leader____

❒ From: ❒ To: Other (specify) ____

My *consent to the release* of information is subject to the following exclusions and limitations: ___________________

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I understand that this **Authorization *to Release Information*** remains in effect for 365 days from the date indicated below. I further understand that I may revoke this authorization at any point during the 1-year period in which it would otherwise be in effect, but only by informing **in writing** all parties indicated above.

____ ___________________________
(Client Signature) (Date)

____ ___________________________
(Client Signature) (Date)

____ ___________________________
(Parent or Guardian Signature) (Date)

____ ___________________________
(Witness Signature) (Date)