Consent to the Disclosure, Transmittal, or Examination of a Psychological Record

I(We)____
(PRINT FULL NAME)

of ____
(Address)

hereby consent to the disclosure or transmittal to, or examination by:

____
(Name of person, agency, or Institution)

of ____
(Identify material: clinical record, report, file, etc.)

compiled/prepared by: ______________________________
(Name or names as appropriate)

in respect of __________________________________
(Name of client(s), or "Myself")

for the purpose of ________________________________

Nature of the information to be released ____________________

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____________________ ____________________
(Signature) (Witness)*

____
(If other than client, state relationship to client)

Dated the _________ day of ____________________.

Expiry Date** ________________________________

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* In the absence of other convenient witnesses the psychologist may serve as witness.

**The client may rescind or amend this authorization in writing at any time prior to the expiry date, except where action has been taken in reliance on the authorization.