PARENTING 🙀 ON CALL

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Dr. Tashya Wilson/Parenting On Call by other individuals or agencies. Such requests should be referred to the original individual or agency.

Ι	, authorize Parenting On Call to:
release to:	
obtain from:	
exchange with:	
the following information pertain	ing to me:
treatment summary	7
history/intake	
diagnosis	
psychological test	results
psychiatric evaluat	ion/medication history
dates of treatment a	attendance
other (specify)	
for the purpose of:	
	ent and/or coordinating treatment efforts
other (specify)	
This consent will automatically e	xpire one (1) year after the date of my signature as it

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

		Date of Birth:	
Signature of Client	Date		
Signature of Witness	Date		