**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.

I _____, authorize Parenting On Call to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to me:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

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