

DIRECTIONS:

Please sign the agreement below giving me permission to release and/or obtain information on your behalf from the individuals and agencies listed below.

CONTACT INFORMATION:

I, _____, give consent for **The Sacramento Institute for Psychotherapy**, it's employees, representatives, and contractors to release and/or obtain any information deemed necessary for my treatment and/or evaluation from the following persons/agencies:

1) Name of Person /Agency: _____

Address: _____

Phone: _____ Fax: _____

2) Name of Person /Agency: _____

Address: _____

Phone: _____ Fax: _____

3) Name of Person /Agency: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE:

The purpose for this information is for: Treatment and Evaluation Other: _____

Specific information being requested/released: _____

TIME FRAME:

This authorization is valid for 5 years or until revoked by me (the patient), whichever comes first.

Patient Name

Guardian Name (if patient is a minor)

Patient Signature

Guardian Signature (if patient is a minor)

Date

Date