CLIENT CONSENT
&
DISCLOSURE OF INFORMATION

I, _____ hereby
(Client, Parent or Guardian)

authorize _____
(Name of Therapist)

to disclose to

_____
(Name of Person, Government or Medical Agency)

_____
(Address and Telephone Number)

the following specific information:

_____

_____

_____

I am aware of and expect that all information is confidential and is protected by the policies of Timothy Weber, Ph.D., the agency requesting and receiving the above information, and by State and Federal regulations.

_____ _____
Date Client/Parent or Guardian Signature

_____ _____
Client Signature Client Signature

Send Original with Request
Copy in client record