Melissa Britt Perrin, Psy.D.

Date_____ Client_____

Address_____

_____

Birthdate_____

Authorization for Release of Information

I authorize _____ to exchange information regarding:

Treatment history Symptoms Course of Treatment

Recommendations Prognosis Concerns Diagnosis

Other _____

with _____ for the purpose of _____.

This consent is valid until _____.

I understand that I may revoke this consent at any time and I have the right to inspect and copy the information to be released. It has been explained to me that if I refuse to consent to this release of information the following consequences apply:

I understand the information obtained as a result of this release may not be redisclosed unless I specifically consent to it.

*Signature _____ Date:_____

_____

Legal Relationship _____

Witness _____ Date: _____

*Client and Parent /Guardian must sign for client between the ages of 12 and 18.

2530 Crawford Ave. Suite 203 Evanston, IL. 60201
Phone: 847-864-8874 and fax: 847-864-8875