Psychotherapist
Jennifer Elder

CONSENT FOR RELEASE OF INFORMATION

I, _____

(print your name in full)

of _____

(address)

_____

consent to the exchange of information between:

_____

(counsellor's name)

and _____

(name of professional, institution or agency)

I understand that any information or documentation exchange will be held inconfidence by both parties.

This consent is given for professional consultation to assess my needs or those of my dependent(s), or to assist in the initiation, coordination, and follow up of any counselling plan that may be formulated.

This Release of Information will expire in 90 days following the date on which it is obtained. The client may withdraw this authorization at any time prior to the date of expiration.

_____ _____

(Client's Signature) Date

_____ _____

(Witness) Date

Jennifer Elder
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