Dr. Sarah Allen & Associates

# Release of Information Consent Form

I, _____, give _____permission to release and receive information regarding my treatment with the following person:

Name:_____

Address & contact details: _____

_____

I do not consent to release the following information:

_____

_____

I understand that I can withdraw my consent at any time.

Signature:_____
Client signature (Client's Parent/Guardian if under 18 years old)

Date: ___/___/___