



Confidential Release of Information

I, _____, hereby consent and authorize Angela Reiter, PsyD, and her associates, to:

Yes/No

Request Verbal Information _____

Request Written Information _____

Release Verbal Information _____

Release Written Information _____

To/from: _____

For the purpose of:

I understand that I may revoke this consent at any time except to the extent that the action based upon this consent has already been taken. This informed consent for the release of information will automatically expire, without further action, ninety days after the date on which it was signed.

I hereby release Angela Reiter, PsyD, and her associates, from all legal responsibility that may arise from the release of the above requested information. This authorization is fully understood and it is made voluntarily and with informed consent on my part.

Signature of Parent/Guardian (if under 18)

Date

Signature of Patient (over 18)

Date

Signature of Psychologist

Date