Consent for Release of Information

I,_____, hereby give permission for Tami Anderson, M.S.
to:

- request the following information from
- give the following information to:

_____.
Name of Person Phone Number

- ❑ Assessment Information
- ❑ Treatment Plan
- ❑ Treatment Progress
- ❑ Diagnosis
- ❑ Medication Management History
- ❑ School Behavior and Academic Reports
- ❑ Legal information
- ❑ Psychiatric Assessments and Medication History
- ❑ Social Services Treatment Plans or Intervention
- ❑ _____
- ❑ _____

I understand that any other information not stated above is confidential and will not be released without my consent. I understand that my records are confidential and will be used for professional purposes only. I furthermore release all parties here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise safeguards while using this information. Permission for such contact expires within 12 months of earliest date below.

_____
Signature Date

_____
Signature Date

_____
Parent or Guardian Signature Date

_____
Witness Date

Tami Anderson, M.S.
3025 Taft Ave, Suite A
Loveland, CO 80538
Business Phone: 970-988-0645