Peter J. Somers, Ph.D., LP

Psychological Consultation / Assessment / Teletherapy

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PERMISSION TO RELEASE / OBTAIN CONFIDENTIAL INFORMATION

CLIENT'S NAME_____DATE OF BIRTH_____

I authorize ***Peter J. Somers, Ph.D., L.P.*** to_____release / _____obtain information about myself / my child to / from:

_____
Name of person / agency

_____
Address

_____
City State Zip Code Telephone #

I understand that this material is confidential, will become part of the case record, and will not be revealed to any other person or agency without written permission. The following information is to be released:

_____Reports of counseling / therapy
_____School records
_____Psychological testing
_____Relevant medical records
_____Other:_____

This information is needed for the purpose of:

_____

_____ _____
Signature of client / guardian Date

_____
Relationship to client if signed by guardian

THIS RELEASE FORM IS VOID ONE YEAR AFTER DATED SIGNATURE OR SOONER IF REVOKED BY THE CLIENT / GUARDIAN

_____