Lynne Goertzen, BJ, MA
Registered Psychologist

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, _____, authorize the
(Printed Name of Client) (Date of Birth)
____ verbal and/or ____ written release and exchange of my otherwise confidential psychological, psychiatric, medical, vocational and/or other information (as specified and/or limited below. The ticks made in the following boxes indicate (a) which party or parties have my permission to disclose information pertaining to involvement with me, and (b) to whom that information may be disclosed.

__**X**_From _**X**_To Lynne Goertzen, Registered Psychologist_____
____From ____To Spouse/Partner/Family Member_____
Address/Phone _____
____From ____To Health Care Professional (i.e., MD) _____
Address/Phone _____
____From ____To Insurance Provider _____
Address/Phone _____
____From ____To Lawyer _____
Address/Phone _____
____From ____To School Representative _____
Address/Phone _____
____From ____To Other (specify) _____
Address/Phone _____

My consent to the release of information is subject to the following exclusions and limitations:

_____

I understand that this **Authorization to Release Confidential Information** remains in effect for 365 days effective from the date indicated below. I further understand that I may revoke this authorization at any point during the 365-day period in which it would otherwise be in effect, but only by informing **in writing** all parties indicated above.

_____ _____
(Client Signature) (Date)

_____ _____
(Client Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

_____ _____
(Witness Signature) (Date)