



Center for Personal Growth

Owner: Erin M Liebich, Psy.D

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Consent to Release and Obtain Records

Client Name: _____

Birthdate: _____

I authorize Center for Personal Growth to **release** information concerning the above named client to:

I authorize Center for Personal Growth to **obtain** information concerning the above named client to:

Name/Agency: _____

Address: _____

Telephone: (____) _____ **Fax:** (____) _____

Please **INITIAL** each item below you wish to have released and/or discussed:

- | | |
|--|--|
| _____ Appointment Days and Times | _____ Treatment Summary |
| _____ Scheduling an Appointment | _____ Psychological Evaluation Report |
| _____ Billing | _____ IEP's, Special Education Records |
| _____ Court/Probation Records | _____ Work Records, HR reports |
| _____ Verbal Communication with Provider regarding treatment | |
| _____ Other (specify) _____ | |

I understand that upon written request, I have the right to revoke this consent at any time.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

| | | |
|--------------|------------|-------|
| _____ | _____ | _____ |
| Signature | Print Name | Date |
| _____ | _____ | _____ |
| Address | City | State |
| (____) _____ | | Zip |
| Phone# | | |

If you are the legal guardian signing on behalf of the child client please see below:

Client is _____ years of age. Any client 12 years and above must sign below:

| | | |
|-----------|------------|-------|
| _____ | _____ | _____ |
| Signature | Print Name | Date |

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Fax/Emailed to: _____ on: _____