THE SIBLEY GROUP

Positive psychotherapy for families, couples & adults

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RELEASE OF INFORMATION

I/We (_____)
authorize Allison Sibley & Associates, PLLC to exchange information with, release to, or receive from concerning:

_____ _____
Client name Date of Birth

With the following people, agencies, or organizations:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

I/we understand that the information will be used for professional purposes only, will not be released to anyone else without written permission, and will consist of and be limited to the following:

Assessment	Ongoing Status
Psychological Evaluation	Psychiatric Evaluation
School Records	Medical Records
Psychosocial/Family History	Treatment Plan
Substance Use/Abuse Evaluation	Legal Records

This consent will terminate on _____. Records of disclosure will be kept in the medical records.

_____ _____
Client (Parent) Signature Date

_____ _____
Witness Signature Date