THE SIBLEY GROUP

Positive psychotherapy for families, couples & adults

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

I also understand that involving this collateral in my child/family's care is only for coordination of treatment, and not for the purpose of providing treatment to the 3rd party. I also understand that I am contracting for services as specified in The Therapy Agreement, which outlines who in the family is receiving therapy, specifically.

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

_____ _____
Client (Parent) Signature Date

_____ _____
Client (Parent) Signature Date

_____ _____
Witness Signature Date