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