CONSENT TO RELEASE INFORMATION
Of Sound Mind, Inc.

I, ______________________________ , consent to release information

regarding my therapy and/or testing with _________________ to the

following individual(s):

____

____.

I do not consent to release the following information (if applicable):

____

____.

This authorization shall expire: _______________________________
Date (not to exceed 6 months)

I understand that I may withdraw my consent at any time.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date