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Authorization to Exchange Information

I, _____ hereby authorize and request that Anna McQuinn, PhD may release all confidential, professional information pertaining to me or my minor children for the purpose of treatment planning and coordination to:

_____

_____

General summary of client history and the following specific information:

_____

_____

_____

I understand that I may revoke this consent at any time by informing the above parties in writing. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature _____ Date _____
(Client)

Signature _____ Date _____
(Parent or Guardian)