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PERMISSION TO REQUEST / RELEASE INFORMATION FOR A MINOR

Date: _____

I, _____, authorize Erica Roush to request
and/or release information concerning my child, _____
from/to: Child's name AND date of birth

Name of individual or organization

Items and information to be released are: _____

I wish to exclude the release of the items and information: _____
_____ (none if left blank)

This information will be used to enhance and benefit psychotherapy. I understand that I may revoke this authorization at any time by giving written notice to Erica Roush. Unless I revoke this authorization prior to such time, this authorization to release information shall expire two years from the date of my signature.

Client Signature
(Parent or Guardian for a Minor)

Date

Witness

Witness's Relationship to Client