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Information Release Agreement

Client ____

Date of Birth _________________________________

Information:

I give my permission for **Dr. Francine Grevin** to obtain and release information about mental and physical health with the following agency or individuals:

____
Person and/or Organization

____
Address

____
Telephone Number

Confidentiality:

The clinician will notify the client any time information is sought from or by another individual or agency, and will request only that information felt to be essential for best client treatment. This release is valid for one year from date of request.

____
Client (Parent or Guardian)

____
Date of Request

____
Client (if couple or other parent)