Evolutionary Wellbeing

Psychotherapy | Evaluations | Consultation
Children · Adolescents · Adults

Informed Consent

Name of Patient: _____

DOB: _____

Address: _____

_____

I, _____, hereby authorize _____
(Patient/Client) (Clinician)

_____ to release to
and/or
_____ request from _____

_____

_____
(Name and Address)

the relevant psychological, psychiatric, educational and/or medical information and records, including the results of any formal evaluations, to assist with diagnosis, treatment and/or coordination of services.

I acknowledge that I have read the above statements and voluntarily consent to the release of my records, including Alcohol and Drug Abuse records and or highly sensitive information, if relevant, for the purpose or need stated above.

I understand that I am free to revoke this consent at any time upon written consent, unless action based on it has already begun. This consent expires 90 days from this date or _____.

_____ _____
Signature of Patient or Patient/Guardian Date

_____ _____
Signature of Patient under 18 years of age Signature of Witness

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