C H A R L E S F. B R I N A M E N, P S Y. D.
C L I N I C A L P S Y C H O L O G I S T

CONSENT FOR RELEASE OF INFORMATION

I, ____, the parent or guardian of
(Adult Client's or Guardian's Name)

_____________________________________, give permission for Charles Brinamen:
(Child's name)

(check and initial below)

_____ to release information regarding me and my child to; ***and/or***

_____ to receive information *regarding me and my child from*

________________________________ ______________________
(Name) *(phone number)*

of ____ *(Agency)*

________________________________ ________________________________
(Address) *(City)* *(State)* *(Zip Code)*

This permission is granted for a period of one year unless otherwise indicated below

(DATES: ______________________).

If the information should be limited, please indicate below what information is allowed:

____

________________________________ ________________________________
(Signature) *(Date)*

________________________________ *(Print Name and Relationship to child)*