# CONSENT FOR RELEASE OF INFORMATION

To: Blue Ridge Psychological Associates

I, _____
*Name of Client (and name of parent/guardian, if applicable)*

Do hereby request and give permission for Blue Ridge Psychological Associates (BRPA) to release and/or acquire all my treatment records and psychological information, including, but not limited to, diagnosis, prognosis, treatment, recommendations, and notes, as well as any other data pertinent to my sessions and/or treatment, to the following:

_____
*Name of individual or institution that you authorize to receive or release a copy of your records*

_____
*Street Address*

_____
*City* *State* *ZIP* *Telephone Number*

_____
*Email* *Fax Number*

I understand that I have no obligation whatsoever to disclose the requested information. In addition, I understand that I may revoke this consent at any time by providing written notice to the aforementioned practice(s). Unless otherwise indicated in writing, this authorization remains valid and in effect.

By signing below, I hereby acknowledge that I agree and understand all the information and the above requirements. I do hereby release and hold harmless Blue Ridge Psychological Associates, Inc., its agents and employees, and Blue Ridge Psychological Associates from any and all liability resulting from the release of this information. I also agree that a scanned or photocopy of this signed document is as valid as the original.

_____ _____
Signature of client or parent/legal guardian Date