OVERSTREET PSYCHOLOGY SERVICES

P.O.Box 720

Florissant, MO 63032

CONSENT FOR THE RELEASE OF CONFIDENTIAL RECORDS

I hereby request that record regarding _____ be released to or obtained from:
(PRINT NAME)

_____
(NAME)

_____
(ADDRESS)

The following information:

_____
(THE EXTENT OR NATURE OF INFORMATION)

The information is needed for the following purpose:

_____

I understand that my records are protected by state and federal law and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that I may refuse to sign this consent form and that signing this form is not a condition of my treatment. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance hereon, and that, unless sooner revoked, this consent will expire on _____ unless otherwise specified. I will be provided with a copy of this form upon my request.

_____
CLIENT SIGNATURE DATE

_____
PARENT/GUARDIAN SIGNATURE DATE

_____
WITNESS SIGNATURE DATE