

**OVERSTREET PSYCHOLOGY SERVICES**

1575 Fairmount Drive, Florissant, MO 63033

**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