**Consent for Release of Information**

**Dr. Kirby K. Reutter**

*DBTC, LMHC, CADAC, MAC, etc.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Licensed Psychologist: Ohio # 7158

Licensed Psychologist: Texas #37448

Licensed Mental Health Counselor: Indiana # 39002367A

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Dr. Kirby K. Reutter and the following party:

(*Please enter the contact information for your adoption agency in this chart)*

|  |  |
| --- | --- |
| Contact Name: | Organization: |
| Address: | Phone: Fax:Email: |

full mutual consent to reciprocally release, share, transmit, and communicate the following information:

[x]  Home Study

[x]  Test Results

[x]  Reports

[x]  Session Notes

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of: Psychological Evaluation

I understand that information regarding myself or my family is protected and cannot be disclosed without my written consent. I further understand that I may revoke this consent any time, except to the extent that action has already been taken. This consent is valid for the duration of one year following the date listed below. A copy of this form shall be as valid as the original.

|  |  |  |
| --- | --- | --- |
| Signature | Birth Date | Date |
| Client  |  |  |
| Witness  |  |  |