AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ _____,
(Name of Client) (Date of Birth)

Authorize the ☐verbal and/or ☐written release and exchange of my confidential medical, psychological, psychiatric, vocational, and/or other information as appropriate

Between the following specific individuals / organizations:

☐ From ☐ To Cobb & Associates Inc.: _____

☐ From ☐ To Spouse/Partner/Family Member: _____

☐ From ☐ To Health Care Professional: _____

☐ From ☐ To Lawyer: _____

☐ From ☐ To Insurance Company: _____

☐ From ☐ To Employer: _____

☐ From ☐ To Ecclesiastical Leader: _____

☐ From ☐ To Other: _____

Subject to the following exclusions and limitations:

_____

_____

_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
(Client Signature) (Date)

_____ _____
(Client Signature) (Date)

_____ _____
(Parent or Guardian Signature, If Required) (Date)

_____ _____
(Witness Signature) (Date)

This release of information remains in effect for one year from the date of signature unless otherwise notified