Stephanie Montague, Ph.D.
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Berkeley, CA 94709
(317) 506-1666

Consent to Release & Request Confidential Information

Client: _____ D.O.B.: _____

I (client/guardian) _____ hereby authorize Stephanie Montague, Ph.D. to exchange confidential information regarding treatment with:

Contact Name & Relationship: _____

Address: _____

Phone/Email: _____

I authorize the release of the following information (circle):

Consultation Clinical Notes School Records

Medical or Hospital Records Psychological Reports

Other: _____

This authorization is in effect until _____, not to last more than one year. I understand that I may cancel or modify this authorization in writing prior to the expiration date. I understand that I have a right to receive a copy of this authorization.

Client Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Therapist Signature _____ Date: _____