RELEASE OF INFORMATION CONSENT

Patient's Name _____ DOB: _____ Month/Day/Year

I hereby give consent for Shaelyn Pham PhD to OBTAIN information about my (or my child's/family member's):

This information can be obtained from:
(please specify particular individuals, programs, ministries, authorities, etc)

Yes	No		Name	Phone	Fax
☐	☐	**Psychological Assessments**			
☐	☐	**Psychiatric Assessments**			
☐	☐	**Medical Reports**			
☐	☐	**Progress Reports**			
☐	☐	**Program/Placement History**			
☐	☐	**Education History**			
☐	☐	**Individual/Personal Service Plans**			
☐	☐	**Other**_____			

I hereby give consent for Shaelyn Pham PhD to RELEASE information about my (or my child's/family member's):

Yes	No				
☐	☐	**Psychological Assessments**			
☐	☐	**Psychological Consultation**			
☐	☐	**Other**_____			

*This consent shall expire at time of discharge

Print Name (Self/Guardian/Representative) _____ Signature _____ Date: _____ Month/Day/Year

Full Address: _____ Tel: _____ Fax: _____