Consent to Release and Receive Information

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I _____ provide permission to Dr. Risa Sanders of Risa E. Sanders, Ph.D., PLLC to discuss my evaluation and/or treatment and/or receive information about my evaluation, health, treatment, or educational issues, or that of my minor child, with the following individual(s).

I understand that this release can be cancelled by me at any time by providing written notice to Dr. Risa Sanders but that it will not impact information that has already been released under this document.

Information may be shared with the following individual or entities:

Name_____ Role: _____

Address: _____

Phone: _____

Signature: _____

Printed Name: _____

Date: _____

If signing on behalf of minor child, please print child's name: _____

Relationship to minor child: _____