Authorization to Release Personal Information

I, _____, hereby authorize
(Name of Client)
Biana Bochkur, PsyD to release records pertinent to services provided to me to:

_____
(Name of Person or Organization to which disclosure is made)

_____
(Address of Person or Organization to which disclosure is made)

The disclosure is required for the following purpose(s):

_____

_____

_____

And such disclosure shall be limited to the following types of information: _____

_____

This consent form is subject to revocation. My consent may be revoked at any time by written revocation. If no express revocation is made, this consent shall terminate in six (6) months from the date of this authorization or upon termination of the services provided to me by Biana Bochkur , PsyD which ever period of time is shorter.

EXPIRATION DATE: _____

X_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian