Allison S. Kress Psy.D. (PY 60558205)

271 Wyatt Way NE Suite 200,
Bainbridge Island, Washington 98110

2500 E. Madison Street Suite 304,
Seattle Washington 98112

(949) 235-6636 drallison@drallisonkress.com www.DrAllisonKress.com

Consent to Exchange Confidential Information (Minor)

I hereby request and authorize exchange of confidential information concerning my minor's case between South County Psychotherapy (its therapists and/or staff) and the individual or agency listed below for purposes of use in my treatment or evaluation. This may include any physician, psychiatrist, psychologist, counselor, attorney, probation officer, school official, or any individual that might have information (medical, psychiatric, psychological, social, or legal) which may have been acquired in a professional capacity concerning my minor. This exchange of information may be in written or verbal form.

Print name of individual or agency with whom you are authorizing that information be exchanged.

Name: _____

Address: _____

_____

Phone No.: _____

Fax No.: _____

This authorization is valid only from _____ to _____.
(Beginning Date) (Ending Date)

_____ _____
Parent's Signature Date

_____ _____
Minor's Signature Date

_____
Print Minor's Name

** You have a right to receive a copy of this authorization and may do so by simply requesting one.*