**Megan Allen, Ph.D.**

**Licensed Psychologist #22150**

**849 Menlo Ave**

**Menlo Park CA 94025**

**650-503-3175**

**Consent to obtain/release confidential information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is being evaluated/treated by Megan Allen, Ph.D.

(child full name and birthdate)

I give permission for:

( ) An exchange of information and records **between** Dr. Allen and the individuals/agencies listed below (include telephone numbers):

( ) A release of records **from** Dr. Allen to the individuals/agencies listed below:

( ) A release of records from the individuals/agencies below **to** Dr. Allen:

Please send medical, educational, psychological, and/or other pertinent information regarding this child and this child’s family to Dr. Allen at the above address.

Thank you for your prompt attention.

These releases are valid for one year from the below date. This voluntary consent may be revoked by the undersigned at any time, except to the extent that action based on this consent has already taken place.

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Parent/Guardian Date

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Parent/Guardian Date