J. Nicol Pate, LCSW
Psychotherapist

CONSENT FOR RELEASE OF INFORMATION

I, _____, give my consent for Nicol Pate, LCSW, to release/receive information regarding:

Client's name _____

Date of birth _____

To/From:
Name _____

Position/agency_____

Phone _____

Address _____

This release expires at the conclusion of treatment, unless otherwise stated here:

_____

I understand that I have the right to review any information released and that in signing this form I release Nicol Pate from all liability surrounding the disclosure of this information to the above-mentioned programs or individuals.

Signature of client _____ Date _____

Signature of parent _____ Date_____
(if client is a minor)

Witnessed by _____ Date_____