Sylva Clinical- PSYCHOLOGY!

Breathe in. Breathe out. Relax...

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize	Sylva Clinical	Associates	and
to exchange information fro	om the record of		
This information shall inclu	ude (nature and	extent of information to	be released):
I understand the contents to there are statutes and regul information. I hereby acknotor:	lations protecting nowledge that thi	g the confidentiality of a	uthorized
-	One Year		
I understand that I may revinformation has already be	oke this consent en released befor	t at any time except to the re I revoke the consent.	e extent that
X	Or		
Client's Signature	_	Authorized Repres Signature	entative's
X s			
Date			
Witness			1
(Necessary only if client sign	ns with an "X") 70 Westcare Driv Sylva, North Care	olina 28779	

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