CONSENT TO RELEASE INFORMATION **Date: _____**

I agree the following agency, clinician, school or other, may release information regarding myself (or my child) as indicated:

Receiving Agency: *Emergence Therapy*
Contact Name: *Mikahla Beutler, LPCC*
Contact Number: *505.663-6464*

Releasing Agency: _____
Contact Name: _____
Contact Number: _____

- ❏ Medication or medical phone consult
- ❏ School/academic success phone consult
- ❏ School/academic success in-person consult
- ❏ Other: _____

Youth printed name:
_____

Youth signature:
_____

Parent printed name: _____

Parent signature: _____