Permission to Release Information
From the Psychology Clinic

Parent: _____Date of Birth:_____SS#_____

By my signature below, I authorize and request

Mediator: _____

At

The Psychology Clinic of Lake Charles
2000 Southwood Drive
Lake Charles, LA 70605

TO RELEASE TO

Name: _____

Address: _____

_____

Any reports indicating arrangements and status of mediation and/or partial or final Memorandum of Understanding.

This form has been explained to me, and I have been given an opportunity to ask questions.

In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom. This authorization, unless revoked earlier, expires one year from the current date.

_____ _____
Date Signature

_____ _____
Date Mediator