Saasha Sutera, Ph.D.

Licensed Clinical Psychologist

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Consent to Release/Receive Confidential Information

1. I, _____,

   am completing this form to allow the use and sharing of my protected health information.

2. I authorize Saasha Sutera, Ph.D. to release/receive information to/from the following provider:

   Name: _____

   Address:_____

   Phone Number:_____

3. The information will be used for the following purposes:

   _____

   _____

4. I understand and agree that this Authorization will be valid for one year from this date

   unless specified otherwise here: _____

5. I understand that I can revoke or cancel this authorization at any time in writing. If I do

   this, it will prevent any disclosures after the date it is received but can not change the

   fact that some information may have been shared before that date.

_____ _____

Signature of client Date

_____ _____

Signature of parent or guardian, if applicable Date