MINDFUL SOLUTIONS, LLC
Psychological Services

2000 14th Street North, Suite 780
Arlington, VA 22201
(p): 703-527-1200

CONSENT TO RELEASE INFORMATION:

CLIENT NAME: (PRINTED) _____

CLIENT SIGNATURE: _____

SIGNATURE OF PARENT (IF UNDER 18 YEARS)

_____

I GIVE MY PERMISSION FOR MINDFUL SOLUTIONS, LLC TO SPEAK TO THE FOLLOWING INDIVIDUALS:

(PLEASE PROVIDE THE NAME, TITLE, PHONE NUMBER, AND /OR EMAIL ADDRESS OF INDIVIDUALS WITH WHOM WE CAN SPEAK BY PHONE/EMAIL:

_____

_____

_____

I GIVE PERMISSION FOR THESE INDIVIDUALS TO: (CHECK ONE)

_____ EXCHANGE INFORMATION

_____ ONLY GIVE INFORMATION (PLEASE SPECIFY WHICH PERSON CAN GIVE AND RECEIVE INFORMATION IF IT IS NOT MUTUAL)

I understand that I can revoke consent at any time, and that I must make this request in writing to the individuals.