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General Authorization for Release of Information

The undersigned, ______________________________________, hereby authorizes Dr. Grace C. Graham, Psy.D and/or her agents, representatives, or employees to accumulate and exchange any and all information with any person that Dr. Graham reasonably believes may be relevant to this consultation. I further authorize her to examine all medical and hospital records, including charts, photographs, bills, electronic or videotape recordings and any other data compilations which relate to or concern any physical or mental condition and subsequent treatment rendered to:

____

I have read this General Authorization and I understand it fully, and voluntarily sign:

____ ______________________
Client, Parent, or Managing Conservator Date