Client Name: _____

Age: _____ Date of Birth: _____

I hereby authorize Lindsey Hoskins & Associates, LLC to release confidential therapeutic information to and receive confidential therapeutic information from:

Name: _____

Relationship to client: _____

Name of business: _____

Address: _____

Phone: _____ Fax: _____

The signature below indicates that I release Lindsey Hoskins & Associates, LLC, from any liabilities or damages of whatever nature may result to me at any time on account of compliance or any attempt to comply with authorization. I further understand that I may revoke this consent at any time except to the extent that action has already been taken.

This consent expires on : _____

_____ _____

Signature Date