KATE REYNOLDS, MA, LPCC

Consent to Release Information

Date: _____

I agree the following agency, clinician, school or other may release information regarding myself (or my child) as indicated:

Information may be released from and to:

Receiving Therapist: Kate Reynolds, MA, LPCC

1421 Luisa Street, Unit C

Santa Fe, NM 87501

Contact Number: 505 670-6454

Releasing Agency:

Contact Name:

Contact Number:

Reason for releasing information

Check all that apply:

- ☐ Medication or medical consultation
- ☐ School/academic consultation
- ☐ Mental health consultation
- ☐ Other:

Youth printed name: _____

Youth signature: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Date upon which this release expires: _____