William Costas, Psy.D.
Licensed Clinical Psychologist
7996 South Vincennes Way
Centennial, CO 80112

Release of Information

I, _____ agree to release clinical information from William Costas, Psy.D. regarding

____myself ____my child ____other family member

To_____

At address: _____

_____

Phone number:_____

_____

(client, parent, legal guardian signature)

_____

Date

I, _____ agree to allow clinical information to be released to William Costas, Psy.D. regarding:

____myself ____my child ____other family member

From: _____

At address:_____

_____

Phone: _____

_____

(client, parent, legal guardian signature)

_____

(date)

I understand that I can withdraw this release permission at any time with a written letter to Dr. Costas _____

(initials)