

Authorization - CONSENT FOR DR. SANDRA YOUNG TO RELEASE INFORMATION

I, _____
(print CLIENT name)

hereby authorize **Dr. Sandra Young, RPsych**, from Dr. Sandra Young, Psychological Services to
RELEASE INFORMATION in writing or verbally, regarding issues related to my assessment
and/or treatment, or the following specific information:

To: _____
(print RECIPIENT name)

Client's Signature

Date

RECIPIENT contact information:

Address: _____

Phone: _____

Fax: _____

Dr. Sandra Young, RPsych #2296
Contact: drsandrayment@hushmail.com
Phone: 778-241-8572

For your information: I will send this completed consent to the RECIPIENT by fax or encrypted email, attempt to contact them to ensure the consent has been received, then arrange a mutually agreed upon time to consult by phone or release records to them.