Ellen Sachs Alter, PhD
Licensed Clinical Psychologist

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Ellen Sachs Alter, PhD to give information to and receive information from:

Name_____

Phone Number Relationship

For use in the evaluation and treatment of:

I understand that this authorization will expire on _____. I understand that I may revoke this authorization by notifying all of the above in writing.

Date	Signature of client (required if client is 12 years of age or older)
Date	Signature of parent or guardian (required if client is under 18 years of age or has been adjudicated incompetent)
Date	Witness

1167 Wilmette Avenue • Suite 206 • Wilmette, IL 60091 • 847-447-6711