**CHARLES E. HOLLAND Ph.D**
**LICENSED PSYCHOLOGIST**

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# RELEASE AND EXCHANGE OF INFORMATION/RECORDS

Client Name: _____ Date of Birth: ____ - ___ - _____
month day year

Social Security Number: ____ - ___ - ____

I hereby give my permission for Dr. Holland to release and exchange all information pertaining to my treatment to:

_____ _____
Person or facility name Address

_____ _____ _____ _____ _____
City State Zip Phone Fax

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing in writing any of the above noted individuals. This release will automatically become invalid 90 days after discharge from care by the above named clinician.

A photocopy of this release is to be considered as valid as the original.

_____ _____ _____
Signature of Client Printed Name Date

_____ _____ _____
Signature of Parent/ Guardian/Representative Printed Name/Relationship Date

_____ _____ _____
Signature of Witness Printed Name Date