



**Sharon Blott**  
Psychological Services

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**CONSENT TO RELEASE/OBTAIN INFORMATION**

**Client Name:**

**Date of Birth:**

I \_\_\_\_\_ give permission to Sharon Blott, Registered Psychologist, to release/obtain information from the files of Sharon Blott Psychological Services regarding the above-named client to/from the following:

Name of Individual: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_

- Consent to release/obtain information is valid for one year.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Psychologist Signature

\_\_\_\_\_  
Date