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## Authorization to Obtain Confidential Information

I, \_\_\_\_\_ hereby authorize and request that  
Client/Parent or Guardian's Name

\_\_\_\_\_  
Name of Information Source

\_\_\_\_\_  
Address and Phone Number

may release all confidential medical, psychological, psychiatric, educational, and or other appropriate information required in the course of my evaluations and treatments or those of

\_\_\_\_\_  
Client or Minor Child/Children

to: Janet M. Hack Psy.D.  
Psychological Assistant  
181 Andrieux Street, Suite 212  
Sonoma, CA. 95476-6920  
(707) 548-8853

I understand that I may revoke this consent at any time by informing the above parties in writing.

I further understand that this authorization is valid for a period of one year from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_