

## CONSENT TO RELEASE OR OBTAIN INFORMATION

I/We, (print names) \_\_\_\_\_  
give consent to Mary Lund, Ph.D. or Angus Strachan, Ph.D. (circle as appropriate), licensed clinical psychologist and Parenting Plan Coordinator, to obtain and release information about (circle as appropriate) myself, ourselves, my, daughter, my son:

(name/s of child/ren) \_\_\_\_\_

to and from the following person:

name \_\_\_\_\_

title \_\_\_\_\_

address \_\_\_\_\_

phone \_\_\_\_\_

email \_\_\_\_\_.

This information is to be used for the purpose of assessment and liaison for the parenting plan coordinator process.

Photocopies of this form are valid consent.

Signed \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_