CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

I, the undersigned, hereby consent to, direct and authorize Dr. Sundar Cook to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Sundar Cook and/or the following person or agency:

_____ of _____

(Name) (Address and Telephone Number)

The information or records to be released or disclosed include:

_____ Initial Evaluation/History
_____ Psychological/Neuropsychological Reports
_____ Medical Information
_____ Therapy Notes
_____ Billing Records
_____ Transfer/Termination Summary
_____ Other (specify):_____
_____ Any and all records/Information

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Sundar Cook from any and all liability arising from release and disclosure of the information and records to the above named person.

_____ _____ _____

Client Name (Printed) Client Signature Date

_____ _____

Client Telephone Number Client Address

Witnessed by:

_____ _____ _____

Sundar Cook, Psy.D (Or Printed name of Witness) Signature of Witness