



CONSENT TO OBTAIN INFORMATION

I, \_\_\_\_\_ consent to and authorize Southwest Counselling Services to obtain any/all necessary documents, records, or information from the following organization, agency, or therapist:

\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that I am waiving my right to confidentiality with Southwest Counselling Services and the organization, agency, or therapist listed above. I am releasing both of these parties from any liability that may arise following the exchange of these documents.

I understand that this consent may be revoked at any time, and all information sharing will be discontinued at that time. I also understand that the information sharing between both parties will automatically be revoked on the following day:

\_\_\_\_\_  
(Date of Termination of Consent)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist as Witness

\_\_\_\_\_  
Date

CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_ consent to and authorize Southwest  
Counselling Services to release any/all documents, records, or information to the  
following organization, agency, or therapist:

\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that I am waiving my right to confidentiality with Southwest  
Counselling Services and the organization, agency, or therapist listed above. I am  
releasing both of these parties from any liability that may arise following the  
exchange of these documents.

I understand that this consent may be revoked at any time, and all information  
sharing will be discontinued at that time. I also understand that the information  
sharing between both parties will automatically be revoked on this date:

\_\_\_\_\_  
(Date of Termination of Consent)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist as Witness

\_\_\_\_\_  
Date