Willowpond Wellness
Psychological Services

Susan J. Gulbe Walsh, Ph.D.
Licensed Psychologist, PSY#21766
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Authorization Consenting To Release Of Information

I authorize Susan J. Gulbe Walsh, Ph.D. to **discuss** (verbally or in writing) content that has been brought up during our psychotherapy or evaluation **with** any person(s) or staff of clinic, office, agency, or institution(s) named below and **receive** any relevant information **from** them.

1. _____
2. _____
3. _____

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Other: _____

I may limit or revoke this consent at any time. I would like to limit disclosure to the following:

_____

_____

This consent is in effect for one year from the date noted below, unless revoked in writing or renewed. This consent is also subject to all conditions outlined in the *Office Policies* form.

_____ _____ _____
Name (print) Date Signature

_____ _____ _____
Name (print) Date Signature