SHERI G. WHITE, Psy.D., P.C.
Licensed Psychologist
Certified School Psychologist

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We, the undersigned, authorize Sheri G. White, Psy.D., P.C. to release/obtain the following information:

_____

_____

to/from: _____

_____

_____

for the purpose (s) of: _____

_____

I/We understand that this release may be revoked at any time and that this release will automatically expire one year from the date of this signing or at the termination of services, whichever occurs last.

_____ _____

Client/Legal Guardian Date

_____ _____

Witness Date