CONSENT AND AUTHORIZATION FORM TO RELEASE INFORMATION

Must be filled out and signed in ink by each adult and all children six (6) years or older. If more than one consent form is needed, you may photocopy this form.

Pursuant to Federal Guidelines concerning my right to confidentiality,
I,_____ ,
authorize **Dr. Rebecca Holton** to release a copy of the psychological assessment report and verbal consultation regarding these findings and recommendations to those named below. If the evaluated person listed above is a minor, then I the parent of said minor do grant release permission, per my signature below.

Great Cities Missions
3939 Belt Line Rd. Suite 705
Addison, Texas 75001
Phone: (214) 466-6200

I understand that I may revoke this consent to release information at any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when I terminate my mission and involvement with my sponsoring eldership. At that time, no express revocation shall be needed to terminate my consent. Finally, I agree to hold harmless all parties mentioned in this release for any consequences of my decision to release this information.

Signature: _____ Date: _____

Signed by: _____
(Printed Name)

Witness Signature: _____ Date:_____

Witnessed by: _____
(Printed Name)

If person evaluated is a minor, fill out information below:

Name of minor:_____

Age of minor: _____ Date:_____

Name of parent or legal guardian: _____

Signature of parent or legal guardian: _____