Robert D. Wells Ph.D. & Associates
1100 W. Shaw Avenue, Suite 134
Fresno, CA 93711
559-228-1618

RELEASE OF INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________

I, the undersigned, consent to release and authorize Robert D. Wells Ph.D. and Associates and the following agencies and/or individuals to exchange medical, social, psychological and educational information regarding the above named person:

Name of Agency or Individual	Address

I do not want the following information to be exchanged:

This release of information will remain in effect until: ______________________

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Patient's Signature Date

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Parent or Guardian's Signature (if Patient is a minor) Date