VICTORIA GOULD, PSY.D.

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CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

I,____, hereby authorize Victoria Gould, Psy.D. to: ☐ provide ☐ obtain or ☐ exchange all information pertinent to my treatment. Authorization is thus granted to Dr. Victoria Gould and/or the following person(s) during the length of my treatment with Dr. Victoria Gould, Psy.D.:

(List name, title and telephone numbers)

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____ ____________________
Client/Guardian Date

____ ____________________
Victoria Gould, Psy.D. Date