



**Dan Kehoe, C.Psych.**  
Psychologist

**Consent to Obtain and Release Information**

**Consent to Obtain Information**

I hereby consent to obtain information pertinent to the assessment and/or therapy for

\_\_\_\_\_ , \_\_\_\_\_

*Name of Client*

*Date of Birth*

I understand that the consent can be revoked at any time and that the information shared is to be kept completely confidential. A copy of pertinent records may be obtained from

\_\_\_\_\_ and be provided to Daniel Kehoe, M.A., C.Psych.

*Name of Individual(s) and/or Agency*

Limitations to this consent to obtain information include \_\_\_\_\_.

**Consent to Release Information**

I understand that this consent can be revoked at any time and that the information shared is to be completely confidential. A copy of pertinent records may be released from

Daniel Kehoe, M.A., C.Psych to \_\_\_\_\_.

*Name of Individual(s) and/or Agency*

Limitations to this consent to release information include \_\_\_\_\_.

\_\_\_\_\_ , \_\_\_\_\_

*Client Signature*

*Date*

\_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

*Parent/Guardian Signature*

*Date*

*Relationship to Client*

\_\_\_\_\_ , \_\_\_\_\_

*Signature of Clinician*

*Date*