LOIS THOMSON BOWERSOCK & *associates, llc*

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CONSENT FORM

Parental Waiver of Right to Child's Records

I hereby waive my right as parent/guardian to obtain information from and copies of any records from Lois Thomson Bowersock & Associates, LLC pertaining to the evaluation and treatment of the following child:

Child's name

Child's birthdate **Child's age**

I understand that Lois Thomson Bowersock & Associates, LLC may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's therapist/counselor would negatively impact the child or the child's evaluation and treatment. I hereby release Lois Thomson Bowersock & Associates, LLC from any and all liability for good-faith refusal to disclose the child's information or records.

Signature of Parent or Guardian **Date:**

Signature of Parent or Guardian **Date:**

As witnessed by:

Lois Thomson-Bowersock. NCAC I, LCDC, ADC III, ICADC
Lois Thomson Bowersock & Associates, LLC **Date:**