

SAMRA PSYCHOLOGY CORPORATION

Director: Dr. Joti Samra
Registered Psychologist
(Reg # 1585)



CONSENT FOR DISCUSSION WITH COLLATERALS

I, _____ hereby request and authorize Dr. Joti Samra, Registered Psychologist, to speak to and/or meet with the following collateral sources, for the purpose of obtaining confidential personal and/or professional information about me:

Name:	Phone Number:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that the discussion(s)/meetings(s) with the individual(s) above are being done for the purpose of psychological treatment being provided by Dr. Samra. The information that can be discussed with the individuals above can include personal, psychological, psychiatric, medical and/or education reports, records, and opinion(s), including information Dr. Samra has obtained from me during the course of her assessment and treatment. I understand that this consent is valid until the termination of this clinical service.

Client Name: _____

Witness Name: _____

Client Signature: _____

Witness Signature: _____

Date: _____

Date: _____

