Dr. U. Koechling Psychology Corporation
**Cell:** 250-213-2331 **Fax:** 250-744-0200 **Phone:** 250-744-0008

Registrant of the College of Psychologists of British Columbia (Registration Number: 1303)

## Consent to Release of Information

I, _____, hereby give consent to Dr. Ulrike M. Koechling, R. Psych., to share the following psychological information: _____

_____

with_____.

I understand that by giving this consent that I am waiving my right to confidentiality with respect to the above-named party and releasing Dr. Ulrike M. Koechling, R. Psych. from any liability arising from the sharing of this information.

I also understand that the person receiving this information may or may not offer assurances of confidentiality.

I have read and understand the terms of this release. I have asked any questions I have regarding this release of information prior to signing my name. By signing this document, I agree to its terms.

Signed and witnessed this _____ day of the month of_____, of the year_____.

_____ _____

**Signature of Client** **Date of Birth**

_____

**Signature of Witness**

**Private and Confidential**

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