LOIS THOMSON BOWERSOCK & associates, llc

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Parental Waiver of Right to Child's Records

I hereby waive my rights as parent/guardian to obtain information and/or 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 Age

_____
Child's Date of Birth

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 Parent or Guardian Relationship

_____ _____
Printed Name Date

_____ _____
Signature Parent or Guardian Relationship

_____ _____
Printed Name Date

As Witnessed by:

_____ _____
Signature Date

_____
Printed Name