Sue Anne Tonkins, Ph.D.
1110 E Chapman Ave. Suite 201 Orange, 92866

AUTHORIZATION FOR RELEASE & RECEIPT OF INFORMATION

Name: _____

☐ Petitioner ☐ Respondent

I hereby give my consent to Sue Anne Tonkins, Ph.D. to release/obtain any information pertaining to myself or my children to/from the following entities (name, email, phone):

	Name	Email	Phone
School Teacher			
Special Ed./PsychoEd			
Pediatrician			
Primary Care Physician			
Child's Individual Therapist			
Child's Psychiatrist			
Adult Individual Therapist			
Adult Psychiatrist			
730 Evaluator			
Court-Ordered Professional			
Attorney for Petitioner*			
Attorney for Respondent*			
Minor's Counsel			
Family Member			
Other:			
Judge*			

1. The purpose of this consent is to facilitate knowledge pertinent to our work together.
2. I understand that this consent will remain effective until services with Dr. Sue Tonkins and Creative Custody Solutions are terminated.
3. I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure/receipt of the above information about, or records of, my families' condition to those persons or agencies above. I further release Dr. Sue Tonkins and her employees, agents or representatives from any liability arising from the said release of information, if done substantially in accordance with applicable law.

_____ _____
Signature Date

*__Please fill out the names of the attorneys on both sides as well as the judge on your case.__