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AUTHORIZATION FOR MUTUAL CONSULTATION

DATE: _____

I, _____, permit ongoing mutual consultation between
_____ and _____ for the
purpose of evaluation and treatment.

I understand that I am free to revoke this release at anytime except to the extent that the person who made the disclosure has already acted upon it. This release will expire when my treatment with Sally G. Hoyle, PhD ends or under the following circumstances:

_____.

Patient or Guardian

Witness

Date

Date