

**WINSTON WILDE, MA, DHS MFC39060**

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# Consent for Release of Information

I, \_\_\_\_\_, am currently a patient of  
Dr. Winston Wilde.

I wittingly and willfully consent to give permission to Dr. Wilde to professionally  
discuss my case with

\_\_\_\_\_  
Name Phone number

I agree that Dr. Wilde may discuss with the above named person any and all  
information I may have revealed to him in the course of treatment, as well as any  
opinions, diagnoses, and interpretations he may have concerning me and my  
psychotherapy treatment.

This agreement will be valid for one year from the date indicated  
below. I may revoke this release at any time by submitting a written revocation to Dr.  
Wilde.

\_\_\_\_\_  
Patient Name Printed Date

\_\_\_\_\_  
Patient Signature