LORA BRADFORD, REGISTERED PSYCHOTHERAPIST, CRPO #003717, M.A. IN COUNSELLING PSYCHOLOGY

Practice supervised by Dr. Bita Sharifzadeh, CPO#53333

From:

Name: ____

Address:

____

Tel./Email: ____

To: **Lora Bradford, RP, MACP**

Lakeridge Counselling and Consulting Services

583 Lakeridge Drive, Orleans, ON K4A 0H3

Consent/Request to Release Information

I request Lora Bradford release the following information from my record *(please specify)*:

____

____

The above specified information is to be released to *(please specify the name of person or organization you wish your information be released to*)

____

____

This consent for release of information is valid from ____________________ to ___________________

(MM/DD/YYYY) (MM/DD/YYYY)

_______________________________________ _________________________

Name of person providing consent Date (MM/DD/YYYY)

____

Signature of person providing consent