Allyson Carlson Psy.D.
dramcarlson@gmail.com
6144 Route 25A Suite 23-24
Wading River, New York, 11792
631.708.5945

Consent to Share Information

I ____, on behalf of my child,

____ (D.O.B.____________________),

consent for Dr. Allyson Carlson to contact any and all personnel to help with his/her treatment.

I also consent to allow her to speak to personnel who contact her regarding treatment regarding his/her treatment.

Signature : ____

Date:______________________