

WINSTON WILDE, MA, DHS MFC39060

152 Lasky Drive, Suite 103 Beverly Hills, CA 90212

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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