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Cheryl Forster, Psy.D. at Bookmark Connections
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SIIC Release of Information

Participant Name:_____ Date of Birth:_____

I hereby consent and authorize **Dr. Cheryl Forster** and _____ (*individual(s) or SIIC staff/faculty*) to maintain verbal and written communication with:

Name of Individual or Organization:_____

Address:_____

_____

Telephone:_____ Fax:_____

For the purpose of:_____

I have read and understood this information. Unless revoked in writing, this authorization will expire in one year from the date it was signed or (earlier) on a specific date:_____.

_____ _____
Signature Date

_____
Telephone Number

Re: Summer Institute for Intercultural Communication (SIIC) (must use pen)