Professional Psychological Services

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AUTHORIZATION FOR RELEASE/ DISCLOSE HEALTH CARE INFORMATION

Name of Client: _____

Date of Birth: _____

I, _____, give consent to Professional Psychological
Client or Parent/Guardian

Services and _____ _____
Name of Agency or Person Phone Number / Email

to exchange information described below.

Check all that apply:

_____ Social History
_____ Assessment Results
_____ Diagnosis
_____ Academic Information/Records
_____ Treatment Planning and Prognosis
_____ Medical Information/Records
_____ Treatment Progress
_____Other (describe)_____

By signing below, I understand and agree for the above information to be exchange and that I may withdraw this agreement at any time. Otherwise, this consent will expire 90 days after the end of treatment.

Printed Name:_____

Signature: _____

Date: _____