Release of Information Authorization

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Release of Information Authorization

Client Name: _____ DOB:_____

Address:

_____

Street City State Zip

I _____ and/or _____ (parent/guardian) hereby authorize and request:

Name of Attorney/Firm:_____

Address:

_____

Street City State Zip

To disclose and receive the following information with the office of Your name/business/practicefor the purpose of completing my psychological evaluation and report and/or_____

Please include only items checked:

___All pertinent information related to my psychological records

___Legal Information ___HIV Status_____

___Discharge Summary ___Psychotherapy Notes_____

___Social History ___Substance Use/Abuse/Dependence

___Evaluations/Assessments ___Other: _____

Expiration Date: _____ Would you like a copy of this form?___

_____ Date: _____

Client's Signature

_____ Date: _____

Signature of parent or legal guardian

_____ Date: _____

Witness Signature