Spectrum Psychological Services
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Federal Way, WA 98003
Phone: (253) 344-1840
Fax: (253) 344-1959
Website: SpectrumPsychologicalServices.com
Email: SpectrumPsychServices@gmail.com

OBTAINING/RELEASING INFORMATION FORM

I, _____, hereby authorize *Spectrum Psychological Services* and its staff to obtain/release information pertaining to my evaluation and/or treatment to/from:

Name of Organization/Person/Professional:_____

Phone #_____ Email: _____

For the purpose(s) of:

_____

PLEASE CHECK ALL APPROPRIATE BOXES:

- ☐ ALL RECORDS.
- ☐ SUMMARY OF MEDICAL HISTORY / TREATMENT
- ☐ PSYCHOLOGICAL TESTING
- ☐ IEP
- ☐ EVALUATION REPORT
- ☐ CLINIC NOTES
- ☐ OTHER (Please Specify):

_____

☐ I **understand that the information in my health record may include information relating to behavioral or mental health services, HIV/AIDS, sexually transmitted disease, drug and /or alcohol abuse. I give my specific authorization for these records to be released.**

I understand that authorization shall remain valid from the date of my signature below and not ending unless specified on this date_____ or revoked.
I have been informed that I may revoke this authorization by written or oral communication to *Spectrum Psychological Services*.

I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Client Date of Authorization

_____ _____
Signature of Parent is Patient is Under 18 Date of Authorization