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/practice for 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