



# PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

## A Clinical and Forensic Psychology Practice Group

### Consent & Authorization For Release of Confidential Information

#### Staff

Tim F. Branaman, Ph.D., ABPP  
Carol Mohney, MSW, Ph.D.  
Kenneth Wise, Psy.D.  
Virginia Secrest, Ph.D.  
Anne Weinberg, Ph.D.

I, \_\_\_\_\_, hereby authorize  
Your name  
\_\_\_\_\_ who is associated with the following organization  
Name of Psychologist or Mental Health Professional at PPS Releasing Information  
\_\_\_\_\_ Professional Psychological Services, P.C.  
Name of Organization Receiving Information

#### Associates

Tim Evans, MS, LPC

to **release confidential information** regarding \_\_\_\_\_  
Your name or name of your legal dependent

#### Practice Established 1984

Tim F. Branaman, Ph.D., CEO

This information will be released to:  
Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Name of Psychologist/Mental Health Professional  
Organization/Agency (if any): \_\_\_\_\_  
Street Address: 600 W. Campbell Road, Ste 2, Richardson, TX 75080  
City, State, & Zip:

The purpose of this disclosure is (describe purpose, or simply write "at my request")

\_\_\_\_\_  
\_\_\_\_\_

#### Information to be disclosed is:

- \_\_\_\_\_ Any and all information pertaining to me
- \_\_\_\_\_ Psychological tests including raw data \_\_\_\_\_ attended counseling sessions
- \_\_\_\_\_ Assessment and diagnostic information \_\_\_\_\_ recommendations given
- \_\_\_\_\_ extent to which following recommendations \_\_\_\_\_ job performance information
- \_\_\_\_\_ progress report \_\_\_\_\_ follow-up information

The method of releasing/obtaining information: Verbally \_\_\_\_\_ Written \_\_\_\_\_ Other \_\_\_\_\_

I am signing this consent and authorization under the following conditions:

- a. My judgement is neither impaired by emotional duress nor any chemicals.
- b. I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken thereupon.
- c. If not withdrawn, this authorization expires on \_\_\_\_\_.
- d. That upon expiration of this release neither agency nor practitioner will discuss information pertaining to me without my further consent except for communication with any insurance company which I have separately authorized or as permitted by law.

\_\_\_\_\_  
Your Signature or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Your Printed Name or Printed Name of Legal Representative