



PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____
Your name Name of your therapist
to seek/release confidential information regarding _____
Your name or name of legal dependent

This information will be obtained from/released to:

Name: _____ Telephone: _____

Organization/Agency: _____

Street Address: _____

City, State, & Zip: _____

The purpose of this disclosure is _____

Information to be disclosed is:

- _____ attended counseling sessions Other (specify) _____
_____ recommendations given
_____ extent to which following recommendations
_____ job performance information
_____ progress report
_____ assessment information
_____ test results
_____ follow-up information

Method of releasing/obtaining information: telephone _____
written _____
other _____

I am signing this consent 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- c. If not withdrawn, this authorization expires on _____.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.

Date

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative