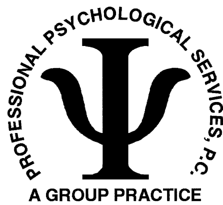

PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

A Clinical and Forensic Psychology Practice Group

Consent & Authorization For Professional Psychological Services To Release Private and Confidential Information

Staff
Tim F. Branaman, Ph.D.
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Post-Doctoral Interns
Mistie Seawell, Psy.D.

Practice Established 1984
Tim F. Branaman, Ph.D., CEO

I, ______________________________________, hereby consent to the release of private
Your name

and confidential information and authorize________________________, who is associated with
Name of mental health professional at PPS

Professional Psychological Services,P.C. to R**elease Protected and Confidential Information** about
Name of Organization Receiving Information

____________________________________. **Release this information to**:
Your name or name of your legal dependent

Name: ______________________________ Telephone:__________Fax: ____________
Name of Psychologist/Mental Health Professional

Organization/Agency (if any):____

Address: ____
Street Name & Number City, State, Zip

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

____

The information to be disclosed and released is:

_______Any and all information pertaining to me
_______Psychological tests including raw data
_______Assessment and diagnostic information
_______Extent to which recommendations are followed
_______ Progress report
_______attended counseling sessions
_______ recommendations given
_______job performance information
_______ follow-up information

The method of releasing/obtaining information is to be: Written Verbal Either/Both
(circle one of above choices)

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

- My judgment is not impaired by emotional duress, drugs or medications.
- I may withdraw this authorization, in writing, at any time except. However, I cannot withdraw authorization for something that has already been released prior to my written withdrawal.
- If not withdrawn, this authorization expires on (Date) ___________________ .
- Upon expiration of this release, neither the organization nor practitioner will discuss information pertaining to the subject of this release without my further consent except for communication with any insurance company which I have separately authorized or as permitted by law. I understand that certain information is required and may be released to insurance companies for purpose of reimbursement.

______________________________ ______________________
Your Signature or Legal Representative Date

____
Your Printed Name

______________________________ ______________________
Signature or Legal Representative Date

____
Printed Name of Legal Representative

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