



**PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.**  
**A Clinical and Forensic Psychology Practice Group**

**Consent & Authorization For Release of Confidential Information To  
Professional Psychological Services, P.C.**

I, \_\_\_\_\_, hereby authorize the following person(s)  
Your name

**Staff**

Tim F. Branaman, Ph.D.  
Carol Mohny, MSW, Ph.D.  
Shaalon Joules, Ph.D.  
Virginia Secrest, Ph.D.  
Anne Weinberg, Ph.D.  
Kenneth F. Wise, Psy.D.

\_\_\_\_\_  
Name(s) of Individual(s) Releasing Records

\_\_\_\_\_  
Name(s) of Individual(s) Releasing Records

\_\_\_\_\_  
Name(s) of Individual(s) Releasing Records

\_\_\_\_\_  
Name(s) of Individual(s) Releasing Records

**to release confidential information regarding**

\_\_\_\_\_  
(Your name or name of your legal dependent (about whom information is to be released))

**Release this information to:**

Name: \_\_\_\_\_ Telephone: 972.669.1266 Fax: 972.664.0381  
Name of Psychologist/Therapist

Organization/Agency: Professional Psychological Services, P.C.

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 | _____ attended counseling sessions |
| _____ Psychological tests including raw data   | _____ recommendations given        |
| _____ Assessment and diagnostic information    | _____ job performance information  |
| _____ progress report                          | _____ follow-up information        |
| _____ Other (specify) _____                    |                                    |

The method of releasing/obtaining information:  
(Circle one or more) Verbally      Written

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

- My judgment is not impaired by emotional duress or any medications or drugs.
- I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken before my withdrawal of authorization.
- If not withdrawn, this authorization expires on \_\_\_\_\_.
- 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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Representative/Guardian