

Psychological and Consultation Services, P.C.
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CONSENT TO RELEASE INFORMATION

I authorize Psychological and Consultation Services (PCS), 4123 Okemos Rd., Ste 15, Okemos, MI 48864 to provide or receive only the following specific information:

PCS may leave messages on patient's phone answering machine or voice mail regarding changes of appointments and other appointment information, accounting information, and return messages left on PCS's answering machine.

Concerning _____
Patient's Name Birth date

To be used only for the following purpose(s): continuation of treatment.

The use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

Signer's Relationship to Patient