

Psychological and Consultation Services, PC
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Consent to Release Information

I authorize Psychological and Consultation Services to receive or provide the following specific information:

Fax, phone, and/or letter correspondence relating to treatment such as diagnosis, treatment plan, progress notes, test scores, testing reports, etc.

To: _____
Name of individual/s, office, or organization to receive information

Address City/State Zipcode

Phone Fax Other contact information

Concerning: _____ DOB: _____
Patient's Name

To be used only for the following purpose/s: Continuation of treatment.

Use of this consent to release information is effective from date signed until the patient informs PCS in writing of any medical treatment team changes. 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 Signature

Date Signed

OR

Parent or Representative's Signature

Date Signed

Signer's relationship to the patient

Witness