Integrative Psychological Services, LLC

REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: Integrative Psychological Services, LLC

to exchange information about _____
(Client's full name and date of birth)

with the following:

Name : _____

Address:_____

_____

Phone: _____

Purpose of release of information:
[ ] Educational planning
[ ] Treatment planning
[ ] Medication consultation
[ ] Other:_____
_____
_____

Nature of the information to be released:
[ ] Copy of Evaluation Full Report
[ ] Written Evaluation Summary
[ ] Written Treatment Summary
[ ] Verbal Exchange
[ ] Other:_____
_____

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release and is made voluntarily on my part.

I understand that I may revoke this consent at any time within ninety (90) days except to the extent that action based on this consent has been taken. This consent will expire automatically after ninety (90) days from the date on which it is signed or upon the fulfillment of the above purposes or on / / 20__.

I also know that I have the right to ask for and receive a copy of this authorization. I agree that a photocopy of this authorization will be as valid as the original.

_____ _____
Client / Legal Guardian Signature Date

_____ _____
Therapist/Evaluator Signature Date