integrativepsychology

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize the Integrative Psychology, PLLC to:

_____ release to:
_____ obtain from:

_____
_____
_____
_____

the following information pertaining to _____:

_____ treatment summary
_____ history/intake
_____ psychological assessment results
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment/education efforts
_____ other (specify) _____

This consent will expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of Client/Guardian Date

Client's Name: _____ Client's Date of Birth:_____