

ASSOCIATED PSYCHOLOGISTS

26081 Merit Circle, Suite 120, Laguna Hills, CA 92653
T: (949)716-5150 F: (949)716-5151

Heidi Berman, Ph.D.

Philip Stein, Ph.D.

CONSENT TO RELEASE AND EXCHANGE INFORMATION

Date: _____

I/We, _____, the _____ of, _____
(name of the client or parent) (state relationship) (child's name is applicable)

do authorize _____
(Put the NAME of the PERSON or AGENCY to release information)

_____ (Put the ADDRESS ABOVE of the person to release information)

_____ (Put the PHONE number of the person to release information)

_____ (Put the FAX number of the person to release information)

to release and exchange information about myself and/or my family to _____

_____ I WOULD LIKE TO ARRANGE A TELEPHONE CONFERENCE WITH YOU AT YOUR EARLIEST CONVIENIENCE.

1. _____ Medical summary.
2. _____ Report or summary of psychological evaluation and/or psychological notes.
3. _____ Report or summary of diagnostic achievement test results.
4. _____ Academic performance and behavior in school.
5. _____ Drug and/or alcohol treatment report/evaluation/summary.
6. _____ Other _____

SIGNATURE OF CLIENT _____ DATE: _____

WITNESS SIGNATURE _____ DATE: _____

A FAXED COPY OF THIS AUTHORIZATION MAY BE USED AS AN ORIGINAL