ASSOCIATED PSYCHOLOGISTS

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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