PSYCHOLOGICAL CENTER
for Expert Evaluations, Inc.

Request to Release or Obtain Information

Client Name: _____ DOB:_____

I authorize clinicians from the Psychological Center for Expert Evaluations, Inc. to:

(Circle one): Request Information Send Information Exchange Information

With the following person or organization: _____

Their contact information (phone/fax/email) is: _____
Information to be released:
____ Entire Contents of File
____ Intake Reports
____ Progress Reports
____ Psychological Evaluations
____ Psychiatric Evaluations
____ Substance Abuse Evaluations/Results of Drug Tests
____ Discharge Summaries
____ Medical Records including Prescription History
____ School Testing Results/Reports, IEP, Grades, Attendance
____ Social, Emotional, Behavioral Functioning
____ Psychosocial/Family History
____ Other (Specify): _____

This information is necessary for:
____ Continuity of Care ____ Legal Purpose ___ Emergency Notification
____ Psychological Assessment ____ Update Records ___ Other (Specify): _____
Please Note: Information may be communicated in written and/or oral form. By signing this form you are indicating that you had a chance to review it and ask questions about it. You are also aware that it is voluntary, that the consent remains in effect for six months (or until revoked in writing), and that the person contacted will be asked to disclose information that will be included in your written report and/or record.

_____ _____
Signature of Client (or Authorized Guardian) Date

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