# *The Way*

Psychological Treatment Center

# Release of Information Consent Form

I, _____, authorize_____

**Name of Patient if minor** _____ Date of Birth ___/___/_____

Requesting Agency:

To: ___ (send) ___ (receive) the following ___ (to) ___ (from) the following agencies of

People:

| Name | Address | City | State | Zip | Phone |
|---|---|---|---|---|---|
| | | | | | |

| Name | Address | City | State | Zip | Phone |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ( ) | Academic Testing | ( ) | Psychological Testing Results | ( ) | Progress Reports |
| ( ) | Behavior Programs | ( ) | Service Plans | ( ) | Psychological Reports |
| ( ) | Case Notes | ( ) | Summary Reports | | |
| ( ) | Intelligence Testing Results | ( ) | Vocational Testing | | |
| ( ) | Medical Reports | ( ) | Entire Record / Date Range: ____/___/___ to ___/____/____ | | |
| ( ) | Personality Profiles | ( ) | Other (specify) _____ | | |

The above information will be used for the following purposes:

| | |
|---|---|
| ( ) | Planning Appropriate Treatment or Program |
| ( ) | Continuing Appropriate Treatment or Program |
| ( ) | Determining Eligibility for Benefits or Program |
| ( ) | Case Review |
| ( ) | Updating Files |
| ( ) | Other (specify) _____ |

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, it's purpose, and who will receive the information.

Signature of Client _____ Date _____

Signature of Parent / Guardian _____ Date _____

Signature of Witness _____ Date _____