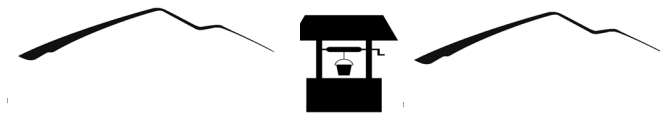


**The Way**  
Psychological Treatment Center



## 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
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Name	Address	City	State	Zip	Phone
<input type="checkbox"/> Academic Testing	<input type="checkbox"/> Psychological Testing Results	<input type="checkbox"/> Progress Reports			
<input type="checkbox"/> Behavior Programs	<input type="checkbox"/> Service Plans	<input type="checkbox"/> Psychological Reports			
<input type="checkbox"/> Case Notes	<input type="checkbox"/> Summary Reports				
<input type="checkbox"/> Intelligence Testing Results	<input type="checkbox"/> Vocational Testing				
<input type="checkbox"/> Medical Reports	<input type="checkbox"/> Entire Record / Date Range: ___/___/___ to ___/___/___				
<input type="checkbox"/> Personality Profiles	<input type="checkbox"/> 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 \_\_\_\_\_