info@pcsmn.com
www.pcsmn.com

PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

763.559.7050
3300 Fernbrook Lane N, #120
Plymouth, MN 55447

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO BOTH RELEASE TO, AND OBTAIN FROM:

_____ _____
(Name of primary care physician) (Address)

_____ _____
(City/state/zip) (Phone/fax)

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Medical Records

Psychological Assessment

General Communication

Other:

The purpose of this information is for assessment and treatment planning. ***This authorization for release and exchange of confidential information is valid for one year from the signature date.***

FROM THE RECORDS OF:

_____ _____
(Name of patient) (Date of birth)

_____
(Address)

I understand:

- **That I have the right to inspect and copy the information disclosed.**
- **That I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed.**
- **That this authorization shall expire without my express revocation one year from the date provided below.**
- **That any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.**
- **That my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided tome for the purpose of creating health information for a third party.**

_____ _____
(Signature of patient or parent/authorized legal guardian) Date

☐ **Checking this box signifies the decision of the patient or parent/authorized legal guardian to opt-out of signing this release of information.**

_____ _____ _____
Patient/Parent/Authorized legal guardian signature Date Provider initials

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(Name of provider) _____ (Address) _____

(City/state/zip) _____ (Phone/fax) _____

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Medical Records	☐	School Records	☐
Speech/Language Evaluation	☐	Achievement Testing	☐
Psychological Assessment	☐	Teacher Rating Scales	☐
Psychiatric Evaluation	☐	504 Plan or IEP	☐
Physical Therapy	☐	Progress Reports	☐
Occupational Therapy	☐	Other:	☐
General Communication	☐		

The purpose of this information is for assessment and treatment planning. ***This authorization for release and exchange of confidential information is valid for one year from the signature date.***

FROM THE RECORDS OF:

(Name of patient) _____ (Date of birth) _____

(Address) _____

I understand:

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(Signature of patient or parent/authorized legal guardian) _____ Date _____