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) (Address)

_____ _____ _____
(City/state/zip) (Date of birth) (Phone number)

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 to me 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) (Address)

_____ _____ _____
(City/state/zip) (Date of birth) (Phone number)

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