

CENTER FOR PSYCHOLOGICAL SERVICES, LLC

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Permission for Release of Confidential Information

Professional requesting Information: _____

Provider of Information: _____

Person Authorized to give permission: _____

Relationship to patient/client/student: _____

I give permission for _____ of *Center for Psychological Services, LLC* to communicate with _____ and exchange information, if necessary, regarding _____.

This information will be used for evaluation, treatment, or psychological consultation regarding _____.

The above permission includes oral communication, request for summaries of treatment, and copies of records, when necessary. This permission is granted for _____ days.

Authorized Person Granting Permission
Signature

Date

Clinician Signature

Date