CONSENT FOR RELEASE OF CONFIDENTIAL CLIENT INFORMATION

This consent authorizes: _____
(Facility/Organization/Individual)

_____
(Mailing Address)

_____
(Phone/Fax Number)

To exchange/release the following information on: _____
(Client Name and Date of birth)

From/To: Family PsychSolutions, PLLC, Provider: _____

For the purpose of: Disability Determination Insurance Claim Care by another provider Other: _____

The information to be disclosed is:

Discharge Summary	Psychological Evaluation
Initial Intake	Progress Notes
Disability Determination Evaluation	Treatment Plan
Other:	Educational Assessment

_____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. This consent will expire in a year from the day signed or the date of discharge.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in the consent and any other use of this information without the expressed written consent of the client is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2). Information to be disclosed may include sexually transmitted diseases, HIV/AIDS, mental illness, and substance abuse. Communication can include both written and verbal.

_____ _____
Client/Guardian Signature Date

_____ _____
Examiner Signature Date