NATIONAL CENTER FOR PSYCHOLOGICAL SERVICES, INC.
LICENSED CLINICAL PSYCHOLOGISTS

TELEPHONE: 808.542.9599
FAX: 808.638.7919
EMAIL: NCPSYCHSERVICES@GMAIL.COM

Authorization for Release of Evaluation Information

Client: _____ Birth date: _____ Social Security #: _____

Address: _____ Phone: _____

Regarding the administration of psychological tests, I give my permission to the provider listed in the letterhead above to release the results of a psychological evaluation of me, the client, in order to:

- ❑ Assist with treatment planning
- ❑ Document a need for services
- ❑ Support an application for (specify): _____
- ❑ Other: _____

I give my permission for the provider listed in the letterhead above to release these records or documentation pertaining to these records to the listed person(s) or organization(s) below:

- ❑ _____

  _____

- ❑ Release to me, the client, to be provided to the following person(s) or organization(s) at my discretion:

  _____

  _____

I hereby release the provider listed in the letterhead above from any liability associated with administering, scoring, interpreting, evaluating, reporting, or transmitting the results of my psychological evaluation/assessment. I understand that the results of my evaluation and/or my provider's written assessment in no way guarantees a provision of services or benefits from any third party.

_____ _____

Signature of Client (or Guardian/Representative) **Date**

_____ _____

Printed Name **Relationship to Client (if Guardian/Representative)**

❑ Copy for client or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records