NATIONAL CENTER FOR PSYCHOLOGICAL SERVICES, INC.
LICENSED CLINICAL PSYCHOLOGISTS

TELEPHONE: 808.542.9599
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Request/Authorization to Release Confidential Records and Information

Client: ______________________ Birth date: __________ Social Security #: ____________

Address: ____ Phone: ____________

I hereby authorize:

Person(s) or facility: ____

Address: ____ Phone: ____________

To release/disclose/discuss the following information with the provider indicated in the letterhead above:

☐ Mental health treatment/evaluations ☐ Developmental and/or social history

☐ Educational records ☐ Medical history and evaluation(s)

☐ Legal history ☐ Other: ______________________________

This release is for the purpose of:

☐ Mental health treatment/evaluation ☐ Other: ______________________________

The released information be disseminated/disclosed to/discussed with my provider by the following method(s):

☐ Phone: ____________________ ☐ Fax: ____________________

☐ e-mail: ____________________ ☐ Postal mail: ______________________________

I fully understand this authorization to release records and information, including the nature of the records, their contents, and the implications of their release. I certify that this request is entirely voluntary on my part. I understand that I may withdraw this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

______________________________ ____________

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

______________________________ ______________________________

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