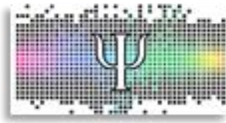

Spectrus Psychological Services, PLLC

info@spectruspsych.com | www.SpectrusPsych.com

Authorization to Obtain/ Exchange Information

____ ________________________
Patient Full Name DOB

____
Street Address City State Zip Code

I do hereby consent to the exchange and/or disclosure of information regarding the evaluation and treatment of the above-named person and acknowledge that I have the legal right to grant this authorization of release of information.

By and Between:

Spectrus Psychological Services, PLLC
____
____
____

____
Full Name

____
Relationship to Patient

____
Street Address

____
City State Zip

____
Phone

The disclosure of information and records authorized herein is done to facilitate the continuity of care and/or to provide assistance with diagnosis, treatment, and treatment planning. I specifically request following information be released to the party indicated above:

☐My complete psychological record
☐Results of psychological evaluation and testing
☐Treatment summary, which includes information from progress notes and treatment plans
☐Other: ____
Specify instructions or restrictions for release of information:
____

I understand that I may revoke this authorization at any time, with the exception of actions which have been taken in reliance on this authorization, and that in any event this consent expires automatically at the expiration timeframe indicated below:

Expiration of consent to obtain/release information: ☐Upon termination of treatment
☐Other: ______________________

____ __________________________
Patient name (Printed) Date of Signature

____ __________________________
Signature of Patient or Authorize Representative Relationship to Patient

____ __________________________
Signature of Witness Date of Signature