



Spectrus Psychological Services, Corp.

info@spectruspsych.com | www.SpectrusPsych.com

Authorization to Obtain & Exchange Information

Patient Full Name Date of Birth

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, Corp / Clinician: _____

And

Name: _____ Relationship: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

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
- Information relevant to making payments
- Information relevant to scheduling appointments
- Other: _____

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 Other: _____

Patient name (Printed)

Date of Signature

Signature of Patient or Authorize Representative

Relationship to Patient