



Consent to Release Psychological Report

Client Name: _____ Today's Date: _____

Parent or Guardian: _____ Signature: _____

Please indicate below the individuals or organizations you wish to automatically receive a copy of the completed assessment report. Your signature authorizes the release of a report, and is valid for 90 days.

Individual / Organization: _____

Address : _____

Fax Number: _____ Email Address: _____

Preferred method of delivery: Email Facsimile Mail

Individual / Organization: _____

Address : _____

Fax Number: _____ Email Address: _____

Preferred method of delivery: Email Facsimile Mail

Individual / Organization: _____

Address : _____

Fax Number: _____ Email Address: _____

Preferred method of delivery: Email Facsimile Mail

DENY

Do not release any assessment data to: _____

Intended to designate an individual who may request a copy of a report but legally has no rights, or is deemed by the client or family as inappropriate to receive such information.