Frederick Psychological Services
2639 South County Trail, East Greenwich, RI 02818 | 401-214-8558

AUTHORIZATION FOR RELEASE OF INFORMATION

I_____for_____
(PATIENT/PARENT/GUARDIAN) **(PATIENT NAME)**

(__/___/__) hereby authorize_____
(DATE OF BIRTH) **(NAME, ADDRESS & PHONE # OF PERSON OR AGENCY MAKING THE DISCLOSURE)**

To release the following information from the record:

- ❑ Classroom Observation
- ❑ Medical Record
- ❑ Psychological Evaluation Test Report
- ❑ Referral Summary
- ❑ Social/Family History (completed by patient)
- ❑ Treatment Summary
- ❑ Verbal Communication
- ❑ Other (specify)_____

To _____
(NAME, ADDRESS & PHONE # OF PERSON OR AGENCY TO WHOM THE INFORMATION IS BEING RELEASED)

The dates of treatment covered by this release are _____

This consent is subject to revocation at any time and if not expressly revoked, this consent will expire 180 days after the date below.

_____ _____
(SIGNATURE OF PATIENT OR PARENT/GUARDIAN) **(DATE)**