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AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOLOGICAL, EDUCATIONAL AND/OR MEDICAL INFORMATION

(This authorization for use or disclosure of psychological,educational or medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1982, Section 56, et seq. California Civil Code.)

Patient Name____Date of Birth___________

I (we) hereby authorize and request Mary Ann Evans, Ph.D. to secure and release confidential professional information, including personal, educational, psychological, psychiatric, and/or medical records and opinions regarding the above named patient. This authorization applies only to the following individuals and/or institutions.

Name_______________________Address________________________Phone_________

Name_______________________Address________________________Phone_________

Name_______________________Address________________________Phone_________

The specific information requested is as follows:

__Case summary highlighting specific therapeutic issues
__Psychological/psychiatric Assessment Report
__School records including test results and transcripts
__Physical exam results and medical history
__Police reports and court documents
__Other____I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing any of the above noted individuals. In consideration of this consent, I hereby release the above parties from any and all liability arising therefore.

____ __________________

Signature Date

Name of Signer (please print)________________________________