PINKSTON PSYCHOLOGY

CLINICAL | NEURO | MEDICAL

CONSENT TO RELEASE OF INFORMATION / WAIVER OF CONFIDENTIALITY

All information gathered on an individual is personal and private.
Such information cannot be released without authorized written permission, except as required by law.

I understand that the information in the record of:

Examinee / Client:	DOB:

is confidential and private. HOWEVER, I GIVE MY PERMISSION FOR:

Name: Pinkston Psychology / Dr. James Pinkston		Fax: 318-553-5099
Address: 2920 Knight St., Ste. 153		Ph: 318-553-5338
City: Shreveport	State: Louisiana	Zip Code: 71105

TO RELEASE TO:

THE FOLLOWING INFORMATION:

Initial

_____ Psychological/Neuropsychological Evaluation Findings & Report

_____ Medication Prescriptions & Treatment Information

_____ Therapy & Counseling Information

I understand that my permission to release this information may be canceled at any time, except when the information has already been released.

My permission to release this information expires on: _____/_____/_____

Examinee (Including Minor)	Date	Witness	Date

The undersigned certifies that he / she is the parent / guardian / representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

Parent/Guardian/Custodial Agency	Date	Witness	Date