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 personal and private. HOWEVER, I GIVE MY PERMISSION FOR:

Names / Institutions:

TO RELEASE TO:

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

THE FOLLOWING:

Background information; History; Observations; Medical records; Reports; Notes; Other records; Raw test data & test protocols

The above information is to be released for the specific purposes of:

Background information and continuity of care

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 will expire on:
_____/_____/_____

Examinee/Client	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.

Guardian/Custodial Agency	Date	Witness	Date