Thrive Psychological and Consulting Services, LLC

Comprehensive Evaluations for Children and Adolescents

Authorization for Release of Information

Name of Client: _____

Date of Birth: _____

I request and authorize: Tonya Klem, Ed. S., NCSP

To obtain from or exchange with: _____
(Name and Address)

_____

_____

the following information:

☐ Academic Records ☐ Teacher Interview
☐ Psychological Testing ☐ Medical History
☐ Other: Other info to be obtained.

for the purpose(s) of: _____

All information I hereby authorize to be obtained from this person or agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that I have the right to inspect and receive a copy of the material to be disclosed. I understand that this authorization will remain in effect for 90 days unless I specify an earlier expiration date here: Earlier Date. I may revoke this authorization at any time except to the extent that information already released pursuant to this consent cannot be recalled.

_____ _____
Signature of Client or Guardian Date

IF PATIENT WITHDRAWS CONSENT

_____ _____
Signature of Client (withdrawn consent before 90 days) Date