

# Release of Information Consent Form

I, \_\_\_\_\_, authorize Steven Drydyk, Ph.D.

to: \_\_\_ (send) \_\_\_ (receive) the following \_\_\_ (to) \_\_\_ (from) the following agencies or people:

Name	Address	City	State	Zip Phone
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Name	Address	City	State	Zip Phone
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Name	Address	City	State	Zip Phone
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- |   |   |
|---|---|
| <input type="checkbox"/> Academic Testing Results<br><input type="checkbox"/> Behavior Programs<br><input type="checkbox"/> Case Notes<br><input type="checkbox"/> Intelligence Testing Results<br><input type="checkbox"/> Medical Reports<br><input type="checkbox"/> Personality Profiles<br><input type="checkbox"/> Progress Reports<br><input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Psychological Testing Results<br><input type="checkbox"/> Service Plans<br><input type="checkbox"/> Summary Reports<br><input type="checkbox"/> Vocational Testing Results<br><input type="checkbox"/> Entire Record<br><input type="checkbox"/> Other (specify) _____<br>_____<br>_____ |
|---|---|

The above information will be used for the following purposes:

- Planning Appropriate Treatment or Program
- Continuing Appropriate Treatment or Program
- Determining Eligibility for Benefits or Program
- Case Review
- Updating Files
- Other (specify) \_\_\_\_\_

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_  
(if client is unable to sign)

Signature of Person Informing \_\_\_\_\_ Date \_\_\_\_\_  
Client of Rights