S. W. Koelemay Psychology, LLC
AUTHORIZATION TO RELEASE/REQUEST FOR INFORMATION

I, ______________________________, authorize **S. W. Koelemay Psychology, LLC** to obtain from, and share information with:

Name: ____

Address: ____

Phone: ____

Regarding: ________________________ ___________ ________________________________ ________
Client's Name Client's DOB Client or Parent/Guardian Signature Date

Witness: ___________________________________ ________
Name Date

Information may include:

________________	Social History	________________	Dental
________________	Psychological Testing/Reports	________________	Immunizations
________________	Hospitalizations	________________	Medical Records
________________	Progress in therapy	________________	Transcripts
________________	Court Reports/Investigative Reports	________________	Test Date
________________	Academic progress	________________	Attendance Data
________________	Placement History	________________	Health Records
________________	Other ________________________	____	

Information to be used for:

________________	Assessment	________________	Leaving School.
________________	Service Planning	________________	Entering School
________________	Continuity of Care	________________	College Admission
________________	Other __________________________	________________	Employment

I understand that I may revoke this authorization to release/request information at any time by giving written notice to **S. W. Koelemay Psychology, LLC**. Without such revocation, this authorization shall expire on ___/___/ (date). (If left blank, ninety (90) days from the date of my signature). I also herewith release **S. W. Koelemay Psychology, LLC** from all liability for releasing such information.

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

I hereby revoke this Authorization to Release/Request for Information:

__________________________ ________ __________________________ ________
Client: Date: Witness: Date:

A copy of this Authorization is as valid as the original.