Authorization for Release of Confidential Information
Pathways Psychological Services, P.A.

7575 Golden Valley Road, Suite 230
Golden Valley, MN 55427
Phone: 763-525-8590 Fax: 763-525-8592

19230 Evans Street N.W., Suite 202A
Elk River, MN 55330
Phone: 763-241-8157 Fax: 763-241-7670

Client Name (print): _____ Date of Birth: _____

I authorize _____ of Pathways Psychological Services, to:

To be completed by Pathways Personnel

___ Exchange information with: ___ Disclose information to: ___ Obtain information from:

Name of Person/Agency: _____

Person/Agency Address: _____

Person/Agency City, State, Zip: _____

Person/Agency Phone: _____ Person/Agency Fax: _____

To be completed by Pathways Personnel

The information to be disclosed is:

____ Any/All Records and Information Obtained
____ Discharge/Treatment Summary
____ Progress Notes
____ Academic Records
____ Psychological Testing & Reports
____ Diagnostic Impressions
____ Chemical Dependency Evaluation
____ Medical History
____ Other: _____

This information is required for the purpose of:

____ Continued, Collaborative, or Follow-up Care
____ Other: _____

I understand that I may revoke this consent at any time by written notice. Without an expressed revocation (unless information has been released) it will expire after 12 months from the date of my signature. I also understand that Pathways Psychological Services ("PPS") only releases records created by PPS personnel. In consideration for furnishing the designated information to the person(s) or organization(s) named, I hereby release and agree to indemnify PPS, its agents and employees from all liability, damages, and costs arising from the acts or omissions of other persons or organizations. I have read and understand the above information:

Client or Authorized Representative Signature: _____ Date: _____

If signed by Authorized Representative, state relationship to client: _____

Witnessed By: _____ Date: _____