

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

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Golden Valley, MN 55427

Phone: 763-525-8590 Fax: 763-525-8592

3145 Wellner Dr NE, Suite 302  
Rochester, MN 55906

Phone: 763-525-8590 Fax: 763-525-8592

19230 Evans St NW, 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: \_\_\_\_\_