DFW Psychological & Consulting Services, Inc.

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Burleson, TX 76028

Release of Confidential Records and Information

I hereby authorize DFW Psychological to release information from records about:

_____, DOB_____

To:_____

_____

_____

For the following purpose:

_____Mental health evaluations

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed Name	Date
_____	_____	_____
Signature of Parent/Guardian/Representative	Printed Name Relationship	Date