Arizona Neuropsychological Services, PLLC
Request/Authorization for Release of Evaluation Information

Client: _____ Birth date: _____ Social Security #: _____

Address: _____ Phone: _____

Regarding the administration of psychological tests, I give my permission to (select only one):

- ❑ the professional named in the letterhead at the top of this form, or
- ❑ _____

of _____

to release the results of the tests taken by me/the patient, in order to:

- ❑ Assist with treatment planning
- ❑ Document a need for services
- ❑ Support an application for
- ❑ Other:

and to send these records to (select only one):

- ❑ the professional named in the letterhead, or to
- ❑ _____

of _____

_____

I hereby release the person or organization sending these records and results from any liability associated with administering, scoring, interpreting, evaluating, reporting, or transmitting the results of these tests.

I understand that the records, information, or results will not be given to me by the evaluator.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

❑ Copy for client or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records