MIND RISING
PSYCHOLOGICAL ASSESSMENT

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415-417-4147

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

I understand that the purpose of this release is to increase communication between Dr. Hassert at Mind Rising Psychological Assessment and other care providers or significant individuals relevant to myself or my child. By signing this release, I authorize Dr. Hassert to release the following information:

__ Acknowledgement of treatment only
__ Relevant diagnostic and treatment information
__ Progress notes or other treatment/evaluation records

I authorize Dr. Hassert to release this information to the following individuals/agency:

Name(s)/Agency: _____

Email:_____

Phone: _____

Mailing Address: _____

_____

In addition, I authorize the above individuals/agency to release the following information to Dr. Hassert.

__ Acknowledgement of treatment only
__ Relevant diagnostic and treatment information
__ Progress notes or other treatment/evaluation records
__ Educational records/information

I understand that I can revoke this authorization at any time except to the extent that it has already been acted upon. Otherwise, this authorization will expire exactly in one year from the undersigned date.

Client or Parent/Guardian Signature (if client under 18 years of age):

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