Michael Crabtree, PhD
Washington Psychological Services
87 East Maiden Street, Suite 2, Washington, PA 15301
(724)222-8525 Fax (724)222-8545

Authorization to Receive and Disclose Information
Note: Washington Psychological will not release or disclose information to a third party.

I am completing this form to allow the use and sharing of information about:

_____ _____
Print Name Date of Birth
Date of Service: All service dates

I authorize this information to be released to or obtained from person or organization listed below:

Name: _____
Address: _____
_____

The purpose from which is: _____

I am authorizing to the above listed the following information:

☐ Inpatient and Outpatient treatment records for physical and/or psychological, psychiatric or emotional illness or drug and/or alcohol abuse.

☐ Psychological or psychiatric evaluations, achievement test, reports, assessments, treatment notes, summaries, or other documents with diagnosis, prognosis, recommendations, or testing records, and behavioral observations or checklist completed by a staff member or the patient, neuropsychological test or similar documents.

☐ All medical records.

☐ All school records, including standardized test scores.

☐ Treatment, recovery, rehabilitation, aftercare plans, discharge summary and other similar plans.

☐ Course of treatment, session notes and treatment plans.

☐ Other: _____

☐ Permission for verbal contact.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. This release expires on _____ (six months from the date of signature if no date is listed).

_____ _____
Signature of Client (if older than 14) Date

_____ _____
Signature of Parent (if client is a minor) Date

_____
Printed name and relationship to minor

_____ _____
Signature of Witness Date