



PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

A Clinical and Forensic Psychology Practice Group

Tim F. Branaman, Ph.D. FICPP, ABPP

Board Certified in Forensic Psychology by the
American Board of Professional Psychology

Consent & Authorization For Release of Confidential Information By Professional Psychological Services

Staff

Tim F. Branaman, Ph.D., ABPP

Carol Mohney, MSW, Ph.D.

Kenneth Wise, Psy.D.

Virginia Secrest, Ph.D.

Anne Weinberg, Ph.D.

I, _____, hereby authorize

Your name

Tim F. Branaman, Ph.D.

who is associated with the following organization

Name of Psychologist or Mental Health Professional Receiving Information

Professional Psychological Services, P.C.

Name of Organization Receiving Information

Associates

Tim Evans, MS, LPC

Practice Established 1984

Tim F. Branaman, Ph.D., CEO

to **release confidential information** regarding _____

Your name or name of your legal dependent

This information will be released to:

Name: _____

Name of Psychologist/Mental Health Professional

Telephone: _____ Fax: _____

Organization/Agency (if any): _____

Street Address: _____

City, State, & Zip: _____

The purpose of this disclosure is (describe purpose, or simply write "at my request")

Information to be disclosed is:

_____ Any and all information pertaining to me

_____ Psychological tests including raw data

_____ Assessment and diagnostic information

_____ extent to which following recommendations

_____ progress report

_____ Other (specify) _____

_____ attended counseling sessions

_____ recommendations given

_____ job performance information

_____ follow-up information

The method of releasing/obtaining information: Verbally _____ Written _____ Other _____

I am signing this consent and authorization under the following conditions:

a. My judgement is neither impaired by emotional duress nor any chemicals.

b. I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken thereupon.

c. If not withdrawn, this authorization expires on _____.

d. That upon expiration of this release neither agency nor practitioner will discuss information pertaining to me without my further consent except for communication with any insurance company which I have separately authorized or as permitted by law.

Your Signature or Legal Representative

Date

Your Printed Name or Printed Name of Legal Representative