



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

Staff

Tim F. Branaman, Ph.D., ABPP

Carol Mohny, MSW, Ph.D.

Kenneth Wise, Psy.D.

Virginia Secrest, Ph.D.

Anne Weinberg, Ph.D.

I, _____, hereby authorize the following person(s)
Your name

Name(s) of Individual(s) Releasing Records

Name(s) of Individual(s) Releasing Records

Associates

Tim Evans, MS, LPC

Name(s) of Individual(s) Releasing Records

Name(s) of Individual(s) Releasing Records

Practice Established 1984

Tim F. Branaman, Ph.D., CEO

to **release confidential information** regarding _____

Your name or name of your legal dependent (about whom
information is to be released)

This information will be released to:

Name: Tim F. Branaman, Ph.D. Telephone: 972.669.1266 Fax: 972.664.0381
Name of Psychologist/Mental Health Professional

Organization/Agency: Professional Psychological Services, P.C.

Street Address: 600 W. Campbell Road, Ste 2, Richardson, TX 75080
City, State, & Zip:

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

Information to be disclosed is:

- | | |
|--|---|
| <input type="checkbox"/> Any and all information pertaining to me | <input type="checkbox"/> attended counseling sessions |
| <input type="checkbox"/> Psychological tests including raw data | <input type="checkbox"/> recommendations given |
| <input type="checkbox"/> Assessment and diagnostic information | <input type="checkbox"/> job performance information |
| <input type="checkbox"/> extent to which following recommendations | <input type="checkbox"/> follow-up information |
| <input type="checkbox"/> progress report | |
| <input type="checkbox"/> Other (specify) _____ | |

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

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

- My judgement is neither impaired by emotional duress nor any chemicals.
- I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken thereupon.
- If not withdrawn, this authorization expires on _____.
- 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

600 West Campbell, Suite 2 Richardson, Texas 75080
Telephone 972/669-1266 • Fax Telephone 972/664-0381
www.ProfessionalPsychologicalServices.com