Trilogy
Integrated
Psychological
Services L.L.C.

Authorization for Release of Information

Client Information

Client Name: _____
Birth Date: _____

Authorization

I authorize Integrated Neuropsychological Services to **disclose, release, and/or receive information** to/from (**circle one**):
Name/Agency: _____
Relation to Client: _____
Address: _____
Telephone:

Information to be Released

_____
_____

Limits of Release: _____

Conditions of Release:

I understand that my signature authorizes the release of this information only between the above named persons or agency. This information may not be made available to others who request it secondarily and will not be re-released to any other person or agency. I understand that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification. I understand that this authorization shall remain in effect for ninety (90) days from the date on my signature below, unless I specify an earlier expiration date in this space:

_____ _____
Signature of Legal Guardian **Date**

_____ _____
Signature of Witness Date

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