Schachner Associates, P.C.

Comprehensive Psychological Services

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Consent to Release and/or Obtain Information

Client Name _____ **Date of Birth** _____

I, (or on my child's behalf), hereby authorize **Schachner Associates**, 128 North Craig Street, Suite 210, Pittsburgh, PA 15213, to:

☐ ***release*** information and records for the purpose of evaluation and treatment to:

☐ ***obtain*** information and records for the purpose of evaluation and treatment from:

Name of Authorized Person: _____ Email: _____

Address: _____

Phone: _____ Fax: _____

The following records are to be released (select all that apply):

PsychiatricMedicalPsychologicalReport Cards/Anecdotal NotesStandardized Test ScoresComprehensive Evaluation ReportIndividualized Educational ProgramSpeech/LanguageOccupational TherapyPhysical TherapyNeurological EvaluationCounseling/PsychotherapyOther (Specify):

Information related to HIV and drug/alcohol evaluation and/or treatment WILL be released unless otherwise indicated:

☐ **Do NOT release information regarding HIV status or alcohol/drug evaluation/treatment.**

Additional Notes:

I understand that, in order to protect the limited confidentiality of my records, my permission to obtain or release information is necessary. I also understand that I may withdraw my consent at any time, except for actions that have already been taken. This release is effective for one year from the date the form is signed, unless otherwise specified.

Client (14 and Older) _____ **Date** _____

Parent/Guardian _____ **Date** _____

Witness _____ **Date** _____