Cognitive Dynamic Therapy of Seattle

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CONSENT TO OBTAIN RELEASED INFORMATION

I hereby authorize __Joseph S. Weiss, PhD_____ to release information from the
(Name of facility, physician, agency, or school)

records of _____, birthdate _____, for the purpose
(Patient)

of psychological evaluation. The information to be released includes:

__ Social History
__ Developmental History
__ Treatment Recommendations
__ Psychological Testing
(Date: _____)
__ Psychological Evaluation
__ Course of Treatment
__ Discharge Summary

__ Attendance Records
__ Birth Records
__ Academic Records
__ Teacher Reports

__Other: _____
_____

__Medical Records
__Summary of Hospitalization
(Date: _____)
__ Lab Reports
__ Neurologicals
__ Medications

Please forward information to the attention of _____ at the address listed above.

I have been told that, in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year from the signature date. I also understand that I can cancel this consent at any time, except for action which has already been taken.

_____ _____
Date of Signature Signature of Client (12 years of age or older)

_____ _____
Signature of Staff Member Signature of Parent, Legal Guardian or Authorized Representative
(when patient is less than 14 years)