

BENJAMIN J. ALBRITTON, PSY.D.

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CLINICAL PSYCHOLOGY

Release of Information

I give permission for _____ to exchange any and all information regarding the following person with Benjamin Albritton, Psy.D. This includes permission for Dr. Albritton to release information to the above designated party.

(Name)

I understand that such disclosure will be made for the purpose for performing a court ordered evaluation or therapy.

This information will include observations, opinions, and impressions, and any other relevant information, specifically including:

- | | |
|---|--|
| <input type="checkbox"/> Psychological records | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Medical information | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Counseling/therapy information | <input type="checkbox"/> Other _____ |

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and in any event shall expire six (6) months from the date of signature. A photocopy of this authorization will be as valid as the original.

Print Name _____

Date _____

Signature _____

Phone _____

Address _____

Fax To: _____

Relationship _____