ALLIANCE

PSYCHOLOGICAL SERVICES

Release of Information Form

Date: ____________________

Re: ____

Date of Birth: ____________________

I / We authorize: Alliance Psychological Services

1135 W. University Dr. Ste. 315A, Rochester, MI. 48307

48562 Van Dyke Ave. Ste. F, Shelby Township, MI. 48317

(248) 413-5027 Fax (248) 413-5048

To release to/communicate with:

____

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Information related to the assessment, diagnosis, treatment plan, psychological testing results, or any other pertinent information regarding the individual named above.

Reason for disclosure: ____

Specifically, I / we DO NOT authorize the release of the following information:

____

____

I / We also authorize the above named individual or institution to release any pertinent information to Alliance Psychological Services.

Patient Name: ____

Patient or Guardian Signature: ____