TREEHOUSE PSYCHOLOGY, PLLC

470 Highway 96 W, Suite 280

Shoreview, MN 55126

(651) 200-3788

Patient/Parent Permission to Obtain/Release Information

Patient Name:_____ DOB:_____

Parent Name:_____

Address:_____

Phone Number:_____

I, the undersigned, hereby request and authorize: Treehouse Psychology, PLLC, 470 Highway 96 W, Suite 280, Shoreview, MN 55126, (651) 200-3788, Fax: 651-203-7370.

Check All that Apply:

• To Release To

• To Exchange With

• To Obtain From

Name:_____

Address: _____

Phone #: _____Fax #: _____

The following information (Check):

• Summary of Therapy

• Copy of Psychological/Neuropsychological Testing

• Phone conversation/Consultation

• Medical Records/Chart Notes

The purpose of this release of information is to coordinate care and services provided with TreehousePsychology, PLLC. This permission is valid for one year from the date above. A copy of this form is as effective as the original. You may revoke this consent form at any time in writing.

Parent/Guardian:_____ Date: _____

* I understand that, except for research-related treatment, Treehouse Psychology, PLLC will not condition my treatment, payment,enrollment, or eligibility for benefits on my signing of this authorization. I do not authorize further release to any third party. I understand that once released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly by this consent and any re-disclosure of that information.