TREEHOUSE PSYCHOLOGY, PLLC

PO Box 481

Hugo, MN 55126

(651) 243-1513

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, P.O. Box 481, Hugo, MN 55038, (651) 243-1513, 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**
- **Diagnostic Assessment**
- **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.

Patient/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.