UNIVERSITY OF CENTRAL ARKANSAS

DEPARTMENT OF PSYCHOLOGY AND COUNSELING

Release of Information

Client's Name (printed in full) _____

I hereby give the University Of Central Arkansas Psychology and Counseling Clinic permission to release the records of my psychological evaluation to the individuals or agencies listed below.

Please list all individuals you would like to receive a copy of this report.

Name and Title	**Address**	**Telephone**

Signature _____
Client Date

Signature _____
Parent or Guardian Date