**Department of Psychology and Counseling**

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**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