TRIANGLE AREA PSYCHOLOGY CLINIC

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Authorization to Release and/or Obtain Information

From: The TAP Clinic, PLLC (includes all TAP Clinic employees and practicum students)

To: _____
Person/Entity
_____
Contact information

To: _____
Person/Entity
_____
Contact information

To: _____
Person/Entity
_____
Contact information

Concerning:
Client: _____
Date of birth: _____

Information to be disclosed: _____
_____

I hereby authorize The TAP Clinic to obtain the information described above regarding myself or my dependent. In addition, I authorize the above named to release the above information regarding myself or my dependent to the TAP Clinic. This release is limited to the parties noted in this document and is authorized within the constraints of confidentiality applicable to all parties.

This authorization is valid for the duration of my treatment at the TAP Clinic and is subject to revocation, in writing, at any time.

Printed name of Client/Guardian_____ Date _____

Signature of Client/Guardian _____ Date _____