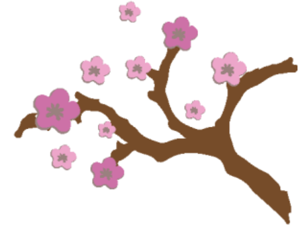
KATRINA L. LOKKEN, PSY.D.

Licensed Psychologist
katrinalokkenpsyd@gmail.com
www.drlokken.com



Request/Authorization for Release of Evaluation Information

Client: ___________________________________ Birth date: ______________
Address: ____
Phone: __________________

Regarding the administration of psychological tests and the corresponding report, I give my permission to Dr. Lokken to release the results of the tests taken by me/the patient, in order to:

- Assist with treatment planning
- Document the need for services (school evaluations)
- Support an application for ________________
- Other:

Permission to Release to: ____

I hereby release Dr. Lokken from any liability associated with administering, scoring, interpreting, evaluating, reporting, or transmitting the results of these tests. I hereby state that I have had read to me and fully understand the above statements as they apply to me and do herein expressly consent to disclosure of the above stated information for the purpose or need to the extent above. I further understand that I **may revoke this consent at any time**, except when disclosure has already been made. I am aware that this information is disclosed from records whose confidentiality is protected by Federal Law. Federal regulations prohibit either party from asking any further disclosures of information shared to any person/organizations not specifically listed on this form without written permission. A general authorization for the release of medical or other information IS NOT sufficient for this purpose.

I UNDERSTAND THAT THE CLINICAL RECORD MAY CONTAIN INFORMATION REGARDING PSYCHIATRIC CONDITIONS, DRUG/ALCOHOL ABUSE, AND MAY CONTAIN HIV TEST RESULTS, A DIAGNOSIS OF AIDS OR AN AIDS-RELATED CONDITION, AND EXPRESSLY CONSENT TO THE RELEASE OF ANY SUCH INFORMATION CONTAINED IN THE RECORDS DESIGNATED ABOVE.

INITIAL _______: I do not want this information released.

I hereby give express consent for the person or organization listed on the following line to provide information to Dr. Lokken which might be beneficial for the purpose of my evaluation or treatment. I hereby state that I have had read to me and fully understand the above statements as they apply to me and do herein expressly consent to disclosure of any information by the provider listed on this line. I further understand that I **may revoke this consent at any time**, except when disclosure has already been made. I am aware that I am waiving my right to confidentiality with my provider in order for Dr. Lokken to receive information.

Permission to Obtain Information From: ____

Client's Signature: ___________________________________ Date:________________

Parent/Guardian Signature:______________________________ Date:________________

286 South Main Street, Suite 200, Alpharetta, GA 30009
Phone: (678) 820-8386 | Fax: 770-234-5889