AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I _____ Date of Birth _____

Authorize _____

to release personal information about me to Stephanie C. Evans, PsyD Clinical Psychologist to assist in her psychological evaluation of me. I understand that such information will be retained by Dr. Evans under my privilege and that I may revoke this privilege at any time prior to her completing her written report for my attorney. I further understand that I and my attorney will review the information, which will be held confidential under attorney-client privilege until such time that I decide to release the report.

PATIENT SIGNATURE:_____DATE: _____

PARENT/REP. SIGNATURE:_____ DATE:_____

WITNESS SIGNATURE: _____DATE: _____