



COLLEGE OF EDUCATION AND ALLIED PROFESSIONS
Psychology Department
WCU Psychological Services Clinic

I hereby authorize _____ of _____
(Clinician) (Agency)

to release information concerning _____
(Client's Name)

to _____
(Name of Individual or Agency Receiving Information)

I understand that the information provided may include anything deemed relevant for the provision of psychological assessment or intervention services, and that such information may be provided through direct interview, phone consultation, and/or written reports transmitted directly, by standard mail, or by confidential fax or email. I know that I may revoke this consent at anytime, except to the extent that action based on this consent has been taken.

Signed _____ or _____
(Client Signature) (Parent or Legal Representative of Client)

Date Signed _____

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