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### Release of Information

I \_\_\_\_\_, authorize \_\_\_\_\_

To: \_\_\_\_\_(send)\_\_\_\_\_ (receive) the following \_\_\_\_\_(to) \_\_\_\_\_(from) the following organization or people:

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Name	Address	City	State,	Zip
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Phone	Fax
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- |   |  |
|---|--|
| <input type="checkbox"/> Academic Testing Results     | <input type="checkbox"/> Psychological Testing Results |
| <input type="checkbox"/> Behavior Programs            | <input type="checkbox"/> Service Plans                 |
| <input type="checkbox"/> Case Notes                   | <input type="checkbox"/> Summary Reports               |
| <input type="checkbox"/> Intelligence Testing Results | <input type="checkbox"/> Vocational Testing Results    |
| <input type="checkbox"/> Medical Reports              | <input type="checkbox"/> Entire record                 |
| <input type="checkbox"/> Personality Profiles         | <input type="checkbox"/> Other (Specify) _____         |
| <input type="checkbox"/> Progress Reports             | _____  |

The above information will be used for the following purposes:

- Planning Appropriate Treatment of Program
- Continuing Appropriate Treatment of Program
- Determining Eligibility for Benefits of Program
- Case Review
- Other (Specify) \_\_\_\_\_

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Psychologist \_\_\_\_\_ Date \_\_\_\_\_