AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____Date of Birth:_____

I hereby request and authorize:

PsyClear, LLC
5055 West Park Boulevard, Suite 400
Plano, Texas 75093
(972) 762-1602

_____To disclose information to:

_____To receive Information from:

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

Information to be disclosed include copies of:
_____Psychological Evaluation
_____Other:_____

Expiration of Authorization:_____

_____Date:_____
Signature of Patient