UTAH PSYCHOLOGICAL ASSOCIATES, LLC
3549 N UNIVERSITY AVE., SUITE 200 PROVO UT 84604
PHONE: (801) 377-2014 FAX: (801) 374-7449

AUTHORIZATION FOR RELEASE/RECEIPT OF CONFIDENTIAL INFORMATION

I, _____, give permission to Utah Psychological
(Name of client or parent/guardian)

Associates, LLC, and specifically _____,
(Name of provider)

to release/receive/share information with the following provider(s):

_____

Name Address/Phone/Fax

_____

Name Address/Phone/Fax

_____

Name Address/Phone/Fax

I understand that if I refuse to consent to the release of the above-mentioned information, it will not be disclosed, except where disclosure is permitted without consent as provided under the Utah Code Mental Health Professional Practice Act (58-60-114.). I understand that I have a right to review the information that I have authorized to be disclosed and may withdraw my consent at any time except to the extent that action has already been taken.

If not earlier revoked, this authorization will be in effect for one year from the date signed, and will automatically become null and void after that year has passed.

_____ _____

Signature of client or parent/guardian Date