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**REQUEST FOR CONFIDENTIAL INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name (if patient is a minor): \_\_\_\_\_

The following person or agency is authorized to release specified records containing confidential information regarding the above-named patient to Dr. King.

\_\_\_\_\_  
Name of Person/Agency

\_\_\_\_\_  
Address

\_\_\_\_\_  
Contact Person

Specific information requested:

- \_\_\_\_\_ Available medical information relevant to the mental health evaluation and treatment of patient
- \_\_\_\_\_ Educational records including transcripts, report cards, attendance records, and results of academic achievement tests
- \_\_\_\_\_ Special Education records including the IEP and results of multi-disciplinary team evaluations
- \_\_\_\_\_ Psychological and Neuropsychological evaluation reports
- \_\_\_\_\_ Psychiatric evaluation reports and admit/discharge summaries
- \_\_\_\_\_ Developmental/medical/social/family histories
- \_\_\_\_\_ Treatment Plan including progress information
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Requested information will be used to facilitate Dr. King's evaluation and/or treatment of the named patient.

This authorization shall remain in effect for six (6) months from the date of signing or the date listed below, whichever is sooner. I understand I have the right to revoke this authorization by providing written notice to the records provider. Revocation does not affect releases of records made prior to the revocation. The records provider is not responsible for any further disclosures of the released information by Dr. King.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if patient is a minor)      Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship      Authorization expires: \_\_\_\_\_  
(six months from date signed)