

Serpas Assessments, Inc.  
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## CONSENT TO RELEASE INFORMATION

I, (Parent/Guardian's Name)

\_\_\_\_\_ ,

authorize Dorothee Serpas, Ph.D. to release information, including a psychological evaluation,  
and authorize communication regarding:

(Child's Name) \_\_\_\_\_ (DOB) \_\_\_\_\_

(Address) \_\_\_\_\_

(Phone) \_\_\_\_\_ (E-mail) \_\_\_\_\_

with the following individuals:

\_\_\_\_\_  
\_\_\_\_\_

Please check any preferences that apply:

- I authorize an electronic copy of the report to be sent to the above persons and acknowledge that all electronic communications are not secure.
- I authorize e-mail contact with the above persons and acknowledge that all e-mail communications are not secure.
- I authorize contact for the time period of \_\_\_\_\_ to \_\_\_\_\_.
- I leave the contact period opened, but understand that I may revoke or limit contact in the future.

I understand that in order to protect the confidentiality of records, my agreement to release information is necessary and that this permission is limited to the purposes and to the persons listed above. While not a required condition for treatment, I understand that specific request is being made for information that will be in my best interest to provide. I also understand that I may revoke this authorization at any time by written request (except for information already disclosed.)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date