EXPERT PSYCHOLOGICAL EVALUATIONS

RELEASE OF INFORMATION

I, _____ _____ _____
(Client or Personal Representative) *(DOB)* *(SSN)*

hereby authorize _____
(Name of Provider/Plan)

to disclose specific health information from the records of the above named client to:
Name: Expert Psychological Evaluations_____ Address:
Fax: _____ _____
Email: Benjamin.Silber@psychological-evaluations.com
Phone Number: _____ _____

Specific information to be disclosed: all records and information relevant to psychological testing, drug screens, educational and academic records, mental health history, medical history, substance use history, consultations, prescriptions, treatment, diagnosis, evaluations, results of tests, and summaries or any illness or injury suffered.

I understand that this authorization will expire on the following date, event, or condition_____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

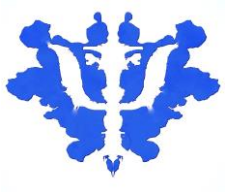
I understand that if my records contain information related to HIV infection, AIDS, or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, psychological or psychiatric conditions, genetic testing, family planning, or women, infants, & children (WIC) this disclosure will include that information.

I also understand I may refuse to sign this authorization and services provided by Expert Psychological Evaluations are not conditioned upon my signed authorization.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

_____ _____
(Signature of Client) *(Date)*

_____ _____
(Signature of Representative) *(Date)*



Expert Psychological Evaluations

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Little Rock, AR 72201

phone: 501-444-2688
fax: 501-404-0390
Benjamin.Silber@psychological-evaluations.com

Consent for Psychological Evaluation

This authorization signifies that Dr. Benjamin Silber has provided the following information:

1. The purpose of the examination;
2. The nature of the procedures (ex. pencil-and-paper tests, oral tests, clinical interview);
3. The intended use of the evaluation (ex. inform legal proceedings);
4. The information gathered may be available to the court, judge, and attorneys involved in the case;
5. The identity of the retaining parties who are requesting the examination;
6. A report may be created. The report will be released to the referral source; the report cannot be released to me. To maintain test security, requests for information will be limited to provision of a report and scores, with the exception that copies of raw test data sheets that can be released to another licensed psychologist;
7. The limitations of confidentiality regarding data gathered during the evaluation, including the legal obligation to report information regarding child abuse, elder abuse, and threats of harm to self/others to appropriate authorities;
8. Dr. Silber may testify about me and this assessment in deposition and trial(s) related to my legal case;
9. No treating relationship exists between myself and Dr. Silber (i.e., there is no doctor-patient relationship). He is not my therapist and will not provide therapy;
10. The importance of performing with my best effort on the testing. Although some might consider exaggerating or minimizing problems on testing, I have been informed that this, rather than helping my case, may actually make my results more difficult to interpret;
11. I am free to terminate the evaluation at any time and can refuse to answer any questions;
12. Even if I interrupt or discontinue the assessment, it is possible (depending on applicable laws, on rulings by the court, and/or decisions by the attorney in this case) that Dr. Silber may be called upon to submit a report and testify about the assessment, even if the assessment is incomplete;
13. Dr. Silber may consult with and exchange information with anyone that may be relevant to this legal matter including collateral contacts;
14. If I am signing for a minor or dependent adult, I attest that I am their rightful legal guardian or conservator;
15. Unless noted otherwise below, a photocopy of this form and my signature is as valid as the original.

By signing below, I am affirming I fully understand and agree to the above-described terms and conditions. I give my consent to Dr. Silber to conduct the psychological evaluation of me.

Sign: _____ Date: _____

_____ _____

(Please Print Name) (Dependent Name if Applicable)