

Thomas M. Krapu, Ph.D.

Psychologist

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PERMISSION TO RELEASE INFORMATION

Client: _____ DOB: ___/___/_____

I (We) hereby authorize and request (name of the person or organization you want me to communicate with such as, "East High School Personnel"):	
Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone: (_____) _____ - _____ Fax: (_____) _____ - _____	

to release confidential professional information, including personal, psychological, psychiatric, and medical records and opinions, resulting from my contacts with them to:

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Saint Louis, Missouri 63123
(314) 842-2258 (voice) (fax on request)
email: tkrapu@krapu4.com
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The information requested is as follows:

- Two-way consultation regarding this individual's current condition.

It is agreed that this information will not be released to any other source without the expressed written permission of the patient or their guardian(s). In consideration of this consent, I hereby release the above parties from any and all liability arising there from. This release of information may be revoked at any time in writing.

Signed _____	Date ___/___/200___
Signed _____	Date ___/___/200___

