



**Toronto Psychological Services
& Research Centre**

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Client's Identifying Information

Client's Full Name: _____

Date of Birth *Month dd yyyy*: _____

Medical Personnel or Other Healthcare Provider

- TPSRC may request the Client's medical records, especially when a diagnosis is contingent on ruling out a medical/organic cause for the Clients' symptoms.
- TPSRC does not provide any information about the assessment or the assessment results, except when the Client request that TPSRC consults with medical personnel/healthcare providers upon completing the assessment. TPSRC charges separately for all Consultations.

Organization Name: _____

Full Legal Name: _____

Honorific Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ None ☐ Other *Specify* _____

Preferred Pronouns: ☐ She/Her ☐ He/Him. ☐ They/Them ☐ Other *Specify* _____

Relationship to Client: ☐ Family Physician ☐ Psychiatrist ☐ Occupational Therapist ☐ Speech Pathologist
☐ Other *Specify* _____

Telephone Number and Ext.: _____

Email Address: _____

Fax Number: _____

Authorized Signatories

I, the undersigned client (or legal guardian if client is younger than 18 years), authorize Toronto Psychological Services & Research Centre to communicate with the named Informant to facilitate the current Psychological Assessment Process.

Signee's Information:

Full Name: _____

Client (18+) / Parent or Legal Guardian Signature _____

TPSRC Representative:

Dr. Ghia Townsend, Psy.D., C. Psych.
Member of the College of Psychologists and Behaviour Analysts of Ontario
Registration #6361
