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Authorization for Release of Information

____ (Name of Patient)   ______________ (Date of Birth)

This form, when completed and signed by you, authorizes me to release the specified protected information from your clinical record to the person/school/agency you designate. It also authorizes me to receive the specified information from the designated person/school/agency.

At my request, I authorize my psychologist/therapist, ______________________________
and/or his or her administrative and clinical staff to release or receive the following information:

_____ Grades and Report Cards
_____ Attendance Records
_____ Special Education Records (Including MDT & IEP)
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Standardized Test Scores
_____ Treatment History
_____ Therapy Records/Progress Notes
_____ Drug and Alcohol Evaluation
_____ SCIP Evaluation

Other: ____

This information may be released or received in written form, during meetings, telephone consultations, and/or email. This information should only be released to or received from (name and address of person):

____

____

I am requesting my psychologist/therapist to release or receive this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

____

This authorization shall remain in effect for one year or until (fill in an event that relates to the individual or the purpose of the use or disclosure) ____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist/therapist generally may not make psychological services contingent upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I agree that this form may be duplicated for the purposes of requesting records and that it may be faxed to the individual(s) named above. Copies or faxes of this release are to be accepted the same as the original copy.

____ Signature of Patient/Parent/Legal Guardian   ______________ Date