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## AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

None of the information or records obtained under this authorization may be re-released to another party.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Date of Birth

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ and/or his or her administrative and clinical staff to obtain or disclose (indicate) the following information:

- |   |   |
|---|---|
| <input type="checkbox"/> Confirmation of participation in therapy | <input type="checkbox"/> Treatment progress                     |
| <input type="checkbox"/> Psychological testing results            | <input type="checkbox"/> Treatment summary                      |
| <input type="checkbox"/> Summary of evaluation findings           | <input type="checkbox"/> Psychotherapy notes (separate release) |
| <input type="checkbox"/> Academic Records                         | <input type="checkbox"/> On-going consultation                  |
| <input type="checkbox"/> Behavior Rating Scales                   | <input type="checkbox"/> Other _____                            |

Indicate if information is to be restricted from disclosure if you have paid for your care out-of-pocket: Yes \_\_\_\_\_ No \_\_\_\_\_

This information is to be released for purpose of: psychological evaluation \_\_\_\_\_, treatment planning \_\_\_\_\_, to coordinate services \_\_\_\_\_, other \_\_\_\_\_

This authorization shall remain in effect until (give date or event): (until revoked) \_\_\_\_\_, (6 months) \_\_\_\_\_, (1 year) \_\_\_\_\_, other \_\_\_\_\_

This information should only be released to or obtained from:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
FAX

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian or Authorized Representative of Patient

\_\_\_\_\_  
Relationship to Patient/Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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 generally may not condition psychological services 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.