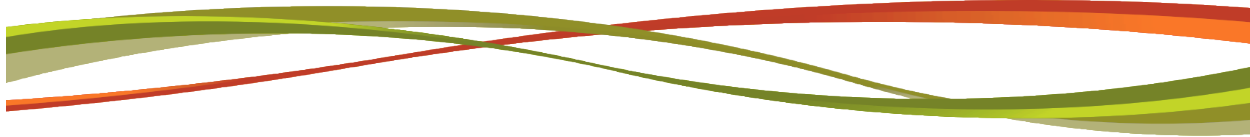
RELEASE OF INFORMATION



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At the request of ________________ ("Psychologist"), patient authorizes ____________________ to disclose ____________________________ ("protected health information") about _________________ (patient) whose date of birth is __________ to _________________________ for the following purpose(s):

- ❏ Mental health evaluation, treatment, or care
- ❏ Neuropsychological assessment
- ❏ Rehabilitation program development or services
- ❏ Treatment planning
- ❏ Other : _________________________

The Psychologist may use or disclose such protected health information only until ___________.

At all times, Patient retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted in writing. The revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization. Patient may revoke this Authorization by sending a letter revoking authorization to the Psychologist's office.

I have been informed and understands that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

I have read and understand this information. i have received a copy of this form and i am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure the protected health information under the above stated terms

_________________________ _________________________ __________________
Signature of client | Printed name | Date

_________________________ _________________________ __________________
Signature of parent/guardian (if appropriate) | Printed name/Relationship | Date

_________________________ _________________________ __________________
Signature of witness | Printed name | Date