MISSION PSYCHOLOGY

PSYCHOLOGICAL ASSESSMENT & TREATMENT

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RELEASE OF INFORMATION

I authorize _____ to disclose records 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 understand 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