Authorization to Release Information

When completed in its entirety and signed by you, this form authorizes Weber Psychological to release protected health information from your clinical record to the person(s) designated below.

I/We ________________________________ do hereby consent to authorize Weber Psychological to:
Client's name

______ Release information to: ______ Secure information from:

______Family Doctor ______School ______Other: ______________________
______Mental Health Practitioner ______Disability Insurance
______Lawyer/Attorney ______Individual

Name of person/practice where information is to be released/obtained:

____

Address: ____
City State Zip

Phone: ___________________________ Fax: ___________________________

Information to be released is:
______For the purpose of treatment planning
______Other: ____

Please release the following:
______Treatment Plan ______Termination Summary ______ Psychological Evaluation
______Clinical Note ______ Progress Reports ______ Recommendations

Other (Please Specify): ____

I understand that this authorization shall remain in effect in perpetuity as of the date of the signature unless otherwise noted. I also understand that this authorization can be revoked at any time, except to the extent that action has already been taken, by submitting dated and written communication requesting so.

I/We understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and is therefore no longer protected by the HIPAA Privacy Rule.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Parent/Guardian or Authorized Representative Date

______________________________ ______________________
Signature of Witness Date