



**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

**RELEASE FROM:**

Today's Date: \_\_\_\_\_

Client: \_\_\_\_\_

DOB: \_\_\_\_\_

**RELEASE TO (PERSON/INSTITUTION):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize my psychologist, \_\_\_\_\_ to release to the above named person or institution:

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment Plan       |
| <input type="checkbox"/> Assessment & Diagnosis   | <input type="checkbox"/> Closing Summary      |
| <input type="checkbox"/> Progress Notes           | <input type="checkbox"/> Statement of Charges |
| <input type="checkbox"/> Other _____              |   |

I authorize the above named person or institution to release to my psychologist, \_\_\_\_\_ .

- |   |   |
|---|---|
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment Plan       |
| <input type="checkbox"/> Assessment & Diagnosis   | <input type="checkbox"/> Closing Summary      |
| <input type="checkbox"/> Progress Notes           | <input type="checkbox"/> Statement of Charges |
| <input type="checkbox"/> Other _____              |   |

The information is being used only for: \_\_\_\_\_

I understand that I may revoke this release at any time, otherwise, this release will automatically expire one year from the date of signature. I also understand that I may revoke this authorization before it expires by providing a written revocation. I further understand that I have the right to inspect disclosed information under appropriate conditions established by my psychologist. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential.

I understand that my psychologist cannot guarantee the confidentiality of documents transmitted by fax or email. I consent to information to be transmitted by: **Fax:**  Yes  No **E-mail:**  Yes  No

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.**  
 No information released under this authorization may be redisclosed without the written permission of the client. I specifically authorize the release of information relating to:

Substance Abuse (alcohol/drug abuse).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (Initial)
Mental Health (includes psychological testing).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (Initial)
HIV-Related Information (AIDS related testing).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (Initial)

  

_____ Client Signature or Client's Authorized Representative	_____ Date
_____ Licensed Psychologist	_____ Date