

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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I, _____

D.O.B.: _____ SS#: _____

hereby authorize the Release Exchange Request
Of the following Protected Health Information (PHI):

PHI From:

Disclose PHI To:

PHI To Be Disclosed:

Purpose of Disclosure of PHI:

Unless otherwise revoked in writing, this authorization expires:

I understand that my records are protected under the laws and regulations relating to the practice of psychology governed by the Board of Psychology (Sections 1012, 1013, & 1014). I further understand that my records cannot be disclosed without my written consent unless otherwise provided for in these regulations. I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire as stated above. By signing below, I acknowledge that I release the above named organization/individual(s) from all legal liabilities that may arise from this situation.

Patient's Signature

Date

Parent/Legal Guardian's Signature

Date

Therapist's Signature

Date

Confidentiality of Records

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making further disclosure of these records without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This authorization for release of information may be considered as an original in instances of fax transmittal.