RELEASE OF INFORMATION AUTHORIZATION

RE: ______________________________ DOB: _____________ SS#: _____________________
Patient

PROVIDERS: ❒ D. Dowding, LMHC ❒ D. Franklin Schultz, PhD
❒ V. Mehnert, LMHC ❒ K. Cohen-Posey, LMHC
❒ ❒ ❒

To ❒ send ❒ receive ❒ exchange the information below ❒ to ❒ from ❒ with: _______________
Name

____ _____________ ______________
Address Phone Fax

Information to be released:

- ❑ 1. Academic Reports
- ❑ 2. Psychological tests
- ❑ 3. Dates of contact only
- ❑ 4. Diagnoses
- ❑ 5. Treatment plans
- ❑ 6. Intake assessments
- ❑ 7. Progress notes
- ❑ 8. Complete record
- ❑ 9. Treatment summaries
- ❑ 10. Evaluations
- ❑ 11. Other:

For the purpose of:

- ❑ Continuity of care
- ❑ Planning treatment
- ❑ Case Review
- ❑ Updating files
- ❑ Determining eligibility for benefits/ programs
- ❑ Necessary communication with ❒ family ❒ courts ❒ employer ❒ school ❒ other: _____________
- ❑ Other:

I understand that have the right to:

- **Receive a copy of this Authorization or refuse to sign it** without any effect on my treatment or benefits.
- **Revoke this authorization** except to the extent that the entities above have already acted on it.
- **Be informed what information will be given**, its purpose, and who will receive it.

I understand that (1) health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and that my health information might be re-disclosed without obtaining my authorization; (2) this Authorization will remain in effect for one year from the date of signature.

____ ________________
Signature of Client or legal representative Date
Legal representatives relationship to client: ❒ Parent ❒ other: ________________

____ ________________
Signature of Witness or Person Informing Client of Rights Date

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