COMPREHENSIVE PSYCHOLOGICAL SERVICES

"SMALL ENOUGH TO CARE, LARGE ENOUGH TO HELP."

AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH RECORD INFORMATION

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____ City/State/Zip: _____

If patient is under 18 years of age Parent/Guardian/ In Loco Parentis:

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Record

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility/Provider: _____ Facility/Provider Phone: _____

Facility/Provider Address: _____ Facility/Provider Fax: _____

City/State/Zip: _____

Dates and Type of Information to disclose:

☐ All records

☐ Dates Other: _____

☐ Specific Information Requested:

_____

Purpose of disclosure is:

☐ Release of Information

☐ Obtain Information

☐ Exchange Information

☐ Other: _____

_____ Diagnosis _____ Psychological Test Results _____ Psychiatric Evaluation/Medical History

_____ Dates of Treatment _____ Progress Notes

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid for the release of medical information dated prior to and including the date on this authorization unless dates are specified.

This information may be disclosed and used by the following individual:

Release to: _____

Address: _____

City/State/Zip: _____

Fax: _____ Phone: _____

Staff Only

Please Mail: ____ Please Fax: ____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Front Office personnel. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.***

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative ***Date***

_____ _____

Signature of Comprehensive Psychological Services Staff ***Date***