Authorization for the Release or Exchange of Information

This form when completed by you, authorizes the release of protected information from your clinical record to the person you designate.

I, _____ (Date of Birth) _____

Authorize _____
(Name of person or organization making disclosure)

To disclose to _____
(Name of person or organization to which disclosure is made)

The following information: (Please check information to be released)

_____ Diagnosis
_____ Medication
_____ Progress & Treatment
_____ Classroom Records
_____ Other _____
_____ Reason for Termination
_____ Recommendations
_____ # of kept/unkept appointments
_____ Psychological Records

The purpose for disclosure is:

_____ Treatment of Client
_____ School Collaboration
_____ Adoption Evaluation
_____ To comply with Physician Referral
_____ To comply with Court Order
_____ Other_____

This consent will expire at the end of 60 days or as specified here:
_____
(Identify date, event or condition which terminates consent)

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However my revocation will not be effective to the extent that Dr. Stone has taken action on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed after the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule, and Dr. Stone is not responsible for any subsequent disclosure. I understand that Dr. Stone generally may not condition treatment services upon my signing an authorization unless the therapy services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian Signature of Witness

NOTE: The receiving agency understands that it CANNOT RELEASE any of the confidential information received without the client's written consent.