

Authorization for Release of Information

REGARDING:		
Client Name:	DOB:	SSN:

I, _____, the client, parent or legal guardian, hereby authorize _____ to RELEASE/OBTAIN the following information from/to: _____
(Therapist)

Address: _____

Phone: _____ Fax: _____

- Summary of Treatment
(Excluding psychotherapy notes as defined by HIPAA)
- Psychological Testing Reports
- Verbal Communication
- Other: _____

Purpose or Need for the Disclosure (check all that apply)		
<input type="checkbox"/> Evaluation/Treatment Planning	<input type="checkbox"/> Case Coordination	<input type="checkbox"/> Legal Proceedings
<input type="checkbox"/> School Placement or Assessment	<input type="checkbox"/> Other _____	

This "Authorization" will expire on _____.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Redisclosure: This information is being disclosed on the condition that it not be redisclosed except as authorized or permitted by applicable Federal or State laws. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Redisclosure may occur in situations such as if my provider's care is reviewed by a state or federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

I have read and understand this form. I am the client listed or am authorized to act on behalf of the client as the client's personal representative. I also permit the disclosures indicated above upon presentation of a photocopy of this authorization.

Date of Signature: _____

Signature of Client or Client's Representative

<p>Stonestreet Professional Offices 5847 SW 29th Street Topeka, KS 66614 Phone: 1-785-273-7292 Fax: 1-785-273-1201</p>
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