



**RELEASE OF INFORMATION
CONFIDENTIAL**

Regarding: _____

DOB: _____
MM/ DD/ YYYY

I consent to allow 3-C Family Services to release and/or exchange information with:

Name of Persons/ Agency: _____

Complete Address: _____

Telephone/Fax Number: _____

This information will include:

- | | | |
|--|--|--|
| <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Testing | <input type="checkbox"/> Behavioral Observations/ Checklists |
| <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Laboratory Work |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> All of the Above | |

Other: _____

Specific Purpose: _____

This authorization shall remain in effect for **one year**, ending ____/____/_____
MM DD YYYY

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that we have taken action in reliance 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 my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Client/ Parent Signature

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.