info@pcsmn.com
www.pcsmn.com

PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

763.559.7050
3300 Fernbrook Lane N, #120
Plymouth, MN 55447

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO <u>BOTH</u> RELEASE TO, AND OBTAIN FROM:

_____ _____
(Name of provider) (Address)

_____ _____
(City/state/zip) (Phone/fax)

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Progress notes/office visits for last 2 visits _____
Last physical exam (within last 3 years) _____
Medications list _____
Labs completed in last year _____
All neuropsychological testing/results including diagnostic assessments and measures _____

The purpose of this information is for assessment and treatment planning, and includes verbal communication. *This authorization for release and exchange of confidential information is valid for one year from the signature date.*

FROM THE RECORDS OF:

_____ _____
(Name of patient) (Address)

_____ _____ _____
(City/state/zip) (Date of birth) (Phone number)

I understand:

- **That I have the right to inspect and copy the information disclosed.**
- **That I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed.**
- **That this authorization shall expire without my express revocation one year from the date provided below.**
- **That any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.**
- **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.**

_____ _____
(Signature of patient or parent/authorized legal guardian) Date