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PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

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AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO BOTH 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 _____ Labs completed in last year _____

Last physical exam (within last 3 years) _____ Medications list _____

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 the duration of treatment in this clinic.*

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 after treatment in this clinic has ended.**
- **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 provider generally may not condition services upon my signing an authorization unless the 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