CAPA | CHILD & ADOLESCENT PSYCHOLOGY ASSOCIATES

Authorization for Disclosure of Health Information and Records

Name of Patient: _____ DOB: _____

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

☐ I authorize the person or facility listed above to release the following information to my provider at Child & Adolescent Psychology Associates.

- ☐ Medical history & evaluations
- ☐ Developmental & social history
- ☐ Psychological evaluation reports
- ☐ School records (ETR, IEP, 504, etc)
- ☐ Treatment summary
- ☐ Other: _____

☐ I authorize my provider with Child & Adolescent Psychology Associates to disclose information about the patient's psychological testing results or treatment services to the listed person or facility. This information may include any evaluation reports, diagnostic impressions, treatment plan, or termination summary.

I understand that this authorization is in effect immediately and will remain in effect for the duration of the professional relationship and for up to 365 days after termination of the professional relationship. I understand that I have the right to revoke this authorization at any time by submitting a request in writing to my provider. I understand that I have the right to refuse to sign this authorization and that it will in no way impact the treatment offered to or received by the patient.

By signing below, I agree that I have read the Authorization for Disclosure of Health Information and Records, and am providing my consent to disclose these records as indicated above.

_____ _____ _____

Patient or Parent/Guardian Signature | Relationship to patient | Date

_____ _____

Witness/CAPA Provider Signature | Date

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