



Amanda DeVillez, PsyD, PLLC

Licensed Psychologist NV# PY0826, CA# 32760

www.amandadevillezpsyd.com

T: 702-483-1599

Authorization for the Release of Information

I, _____, Date of Birth: _____, authorize Amanda DeVillez, Psy.D., PLLC to:

Disclose Information to:

Receive Information from:

Name/Title of Person/Organization: _____

Address of Person/Organization: _____

Phone: _____

Fax: _____

The following information:

Description of Information to be Released

(Client should initial next to each item to be released)

___ Assessments

___ History/Physical

___ Evaluations and records

___ Labs/X rays/Lab results

___ Drug and alcohol treatment information*

___ Consultation Reports

___ HIV/AIDS related information**

___ Progress notes and Treatment Plans

___ Legal Records

___ Educational Records+

___ Other (describe): _____

___ Financial Records

___ Medical information including but not limited to medical and hospital records

___ Mental health information, including psychological testing information and evaluations***

___ I authorize the periodic use/release of the information described above to the person/organization identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

One (1) year from the date of signature or sooner as specified by a condition or event.

Describe condition or event: _____

Signature

Date

Printed Name

* Drug or alcohol treatment information may be redisclosed with explicit authorization provided when necessary in a medical emergency, to qualified personnel for the purpose of scientific research, audits or other specified reasons as long as the individual is not identifiable, or if authorized by a court of competent jurisdiction.

With some exceptions, HIV/AIDS – related health information, or mental health treatment information may be re-disclosed by the recipient. **The recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without the specific written consent of the person to whom it pertains, unless permitted to do so under federal or state law.

***Information from mental health clinical records may be released if there is a **demonstrable need for the information**, provided that the disclosure will not reasonably be expected to be detrimental to the participant or another person.

+ If the authorized information is protected by the Family Educational Rights and Privacy Act it may not be disclosed without the written consent of the person to whom it pertains unless otherwise provided for in federal or state law.