Solara Psychological

Dr. Arthur R. Cardona

Clinical Psychologist

2525 Kell E Blvd #405
Wichita Falls, TX 76308
Voice: 940-340-5194
Email: admin@solarapsych.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:_____

Date of Birth: _____

Phone Number: _____

I, _____, authorize Solara Psychological Services to:**
(Check all that apply)

- ☐ Release information to the party listed below
- ☐ Obtain information from the party listed below
- ☐ Exchange information with the party listed below

Recipient of Information:

Name/Organization:

_____

Address:

_____

Phone:

_____

Fax:

_____

Information to Be Released (Check All That Apply):

- ☐ Psychological Evaluation Report
- ☐ Therapy Progress Notes
- ☐ Diagnosis and Treatment Plan
- ☐ Medication and Medical History
- ☐ Insurance and Billing Information
- ☐ Entire Record (except psychotherapy notes)
- ☐ Other (please specify): _____

Purpose of Disclosure:

- ☐ Coordination of Care
- ☐ Insurance/Billing
- ☐ Legal Purposes
- ☐ Personal Request
- ☐ Other: _____

Acknowledgment and Terms:

I understand that this authorization is voluntary and that I may revoke it at any time by submitting a written request, except to the extent that action has already been taken based on this authorization. I understand that once my information is disclosed, it may no longer be protected under HIPAA regulations.

This authorization expires **one year from the date signed**, unless otherwise specified: **Expiration Date:** _____.

Client Rights:

- I have the right to receive a copy of this form.
- I have the right to refuse to sign this authorization, and my refusal will not affect my ability to obtain treatment.
- I understand that Solara Psychological Services cannot condition treatment, payment, or enrollment on signing this authorization.

Signature:

_____
(Client or Legal Representative)

Relationship (if signed by Legal Representative):

_____

Date: _____

For Office Use Only

Authorization received by:

_____
Date received:

_____
Staff Signature:

_____