Christy Pulsford MSW, LISW-S, LICDC
GrowthINsight Counseling LLC
Affiliate of Macks Psychology Group
8050 Beckett Center Drive Suite 314, West Chester, OH 45069
Phone: (513) 847-3891 Office: (513) 204-5746 Fax: (513) 229-3707

Authorization for Release of Information

I hereby authorize:

- Macks Psychology Group
- Christy Pulsford MSW, LISW-S
- GrowthINsight Counseling LLC

to exchange information with

Name: ____
Address: ____
Phone: ______________________________ Fax: _______________________________

I authorize the following information to be released about the below-named patient/client:

Name of Patient: _____________________________________ DOB: ____________________

- ○ Diagnostic Evaluation / Assessment
- ○ Discharge Summary & Treatment Summary
- ○ Treatment Plan
- ○ Consultation Summary
- ○ Progress Notes
- ○ Psychological/Speech evaluation reports
- ○ Medical history & evaluation
- ○ Other________________________

I fully understand this request/authorization for release of records between my provider and the above-named person or facility. I understand that this authorization is effective immediately and will remain in effect for the duration of the professional relationship for professional services between by my provider and the above-named patient, and for up to 365 days after termination of this 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 may refuse to sign this authorization, and that my provider may not condition my treatment upon whether I do so. I understand that if I authorize the disclosure of information to someone who is not legally required to maintain confidentiality, the recipient may re-disclose it, and it may no longer be protected. I understand that I have the right to inspect or copy the protected health information to be used or disclosed.

By signing below, I indicate that I have read the Authorization for Disclosure of Health Information and Records, and offer my consent to disclose those records indicated above.

____________________________________ ________________________ ______________
Patient/Client or Parent/Guardian Signature Relationship to Patient/Client Date

_____________________________________ ________________
Witness or MPG Provider Signature Date