



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.

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.

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