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Charlotte Psychological Assessment, PA
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Consent to Release Information

I am completing this form to allow the use and sharing of protected health information about myself, or as a guardian for _____

I authorize for Dr. Nicole L. Cantley to CONTACT _____

and/or RELEASE TO _____

the following information:

_____diagnosis
_____assessment/evaluation report
_____medical records
_____test data
_____other (must specify)_____

This release covers dates of evaluation FROM:_____ TO:_____

I agree that this Authorization will expire on:_____

I understand I can revoke or cancel this authorization at any time by putting such a request in writing, and providing it to Dr. Cantley. If I do this, it will prevent any releases after the date it has been received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Cantley, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization, as permitted by all applicable laws. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____
Signature of client or legal representative Date

_____ _____
Printed name of client or representative Relationship

I acknowledge that I have received a copy of this form. _____
Signature