LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

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Authorization to Release/Receive Confidential Records and Information

I hereby authorize Lucy T. Smith, PhD, to release and receive personal health information about _____, born on _____,

to/from: Name: _____

Address: _____

_____

Phone: _____

E-Mail: _____

Relation to Client: _____

For the purpose of *(check all that apply)*:

□ Further mental health evaluation, treatment, or care
□ Treatment planning
□ Research
□ Other: _____

Type of information to be disclosed/obtained *(check all that apply)*:

□ Intake and discharge summaries
□ Mental health evaluations
□ Treatment progress
□ Medical history
□ Other: _____

I have had explained to me and fully understand this authorization to release/receive records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent is valid until *(indefinite if left blank)* _____, or upon fulfillment of the purposes stated above. I also understand that the information being disclosed pursuant to this authorization may be subject to redisclosure of the recipient, and may no longer be protected by the privacy rule.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian	Printed name	Date