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AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

This form when completed and signed by you, authorizes the release of protected health information (PHI) from your records to the person(s) you designate.

Name:_____Date of Birth:_____

Address:_____
Street, Apt. or Ste. #, City, State, Zip Code

Authorize:_____ _____
Name of Person or Organization Making Disclosure/Exchanging Information

_____
Street, Apt. or Ste. #, City, State, Zip Code, Phone #, Fax

To Disclose to/Exchange with:_____
Name of Person or Organization to Which Disclosure is Being Made/With Which Information is Being Exchanged

_____
Street, Apt. or Ste. #, City, State, Zip Code, Phone #, Fax

The Following Information: (Please check reports or information to be released)

_____ Diagnosis
_____ Medication
_____ Social History
_____ Psychological Testing Results and Report
_____ Other_____
_____ Recommendations
_____ Progress/Treatment Summary
_____ Alcohol/Drug-Related Information
_____ Classroom / Medical / Psychological Records

Please specify exact information to be released

The Purpose for Disclosure is: (Please check reason(s))

_____ Treatment of Client
_____ Collaboration with School
_____ Other_____
_____ Doctor Referral/Coordination of Care
_____ Comply with Court Order

Please specify exact purpose of disclosure

This consent will expire at the end of 180 days or as specified here:_____
Please specify date, event, or condition of termination

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, my revocation will not be effective to the extent that Dr. Hunnicutt has taken action on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. I understand that information used or disclosed after the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule, and Dr. Hunnicutt is not responsible for any subsequent disclosure. I understand that Dr. Hunnicutt generally may not condition treatment services upon my signing an authorization unless the therapy services are provided to me for the purpose of creating health information for a third party.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Angela Hunnicutt, Ph.D., HSPP Date

Note: The receiving agency understands that it CANNOT release any of the confidential information received without the client's specific written consent.