JONATHAN D. ROBBINS, Psy.D.

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Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

☐ **I authorize Jonathan D. Robbins, Psy.D. to release information to:**

AND/OR

☐ **I authorize Jonathan D. Robbins, Psy.D. to obtain information from:**

Name of Provider or Facility	**Name of Provider or Facility**
Address	**Address**
City, State, Zip Code	**City, State, Zip Code**
Phone #/Fax # (Include area code)	**Phone #/Fax # (Include area code)**

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal**

☐ **Other:** (please describe)_____

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/or Treatment**

☐ **Other:** (please describe)_____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans** ☐ **Treatment Summary**

☐ **Other:** (please describe)_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.

☐ 90 days from this date. ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

☐ When I am no longer receiving services from Jonathan D. Robbins, Psy.D.

☐ One year from this date. ☐ Other: _____

I understand that:

- I understand that I have the right to refuse to sign this Authorization.
- I may cancel this authorization prior to the release of the information by submitting a *written* request to Jonathan D. Robbins, Psy.D, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of the facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports.

Signature of Student or Representative: _____ Date: _____

Relationship to Client (*if requester is not the client)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____