Authorization for the Release of Protected Mental Health Information

Client's Name _____ Date of Birth _____

By signing this form, confidential psychological information can be released to and/or discussed with the people or organizations listed below. This form is signed voluntarily and you may make changes at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

I, _____, authorize A. Shayne Abelkop, PhD, PC to:
Client name or Parent/Guardian

Circle one: GIVE records to GET records from EXCHANGE between Dr. Abelkop and the listed person below

_____
Person/Organization Address/Phone/Fax

Purpose of disclosure: ☐ Coordination of Care ☐ _____

Description of mental health information to be disclosed:
☐ Clinical Intake/Summary of treatment ☐ Phone consultation with Dr. Abelkop
☐ Letter of Clinical Support ☐ Entire Medical Record
☐ Only the following information: _____

Exclusions or limitations: _____

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. Unless otherwise revoked, this authorization will expire within one year of the date signed, and/or when treatment is terminated. I further understand that the information disclosed to the recipient may not be protected under these guidelines if the recipient is not a health care provider covered by state and federal rules. I give permission for a faxed or photocopied signature to serve as the original signature regarding this authorization.

Client or Parent Signature: _____ Date: _____

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