porch light
PSYCHOLOGY, INC.
Welcoming you back home.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT	DOB	SSN
PERSON OR ENTITY TO RECEIVE INFORMATION		
RELATIONSHIP TO PATIENT		
ADDRESS		
PHONE	FAX	

I hereby authorize an exchange of the information specified below between the person or entity listed above and Porch Light Psychology, Inc. for the purpose of assisting in psychotherapy.

INFORMATION REQUESTED

_____ Please provide _____

_____ Porch Light Psychology, Inc. will provide _____

_____ Information to be exchanged _____

Purpose of information to be exchanged _____

Verbal, written, and digital information to be exchanged is limited to records deemed necessary and appropriate for patient care by Porch Light Psychology, Inc. None of the information or records received or obtained under this Authorization may be re-released to another party. A photocopy of this Release is considered as effective as the original.

This Authorization for Release of Information shall remain in effect until withdrawn by the Patient and/or authorized Patient Representative. This Authorization for Release of Information may be withdrawn at any time by the Patient and/or authorized Patient Representative. Any such withdrawal shall be in writing by the Patient and/or authorized Patient Representative. If withdrawn, said Withdrawal of Authorization for Release of Information has no effect upon any and all previous action(s) taken in reliance on any Authorization for Release of Information, previously executed by the undersigned patient, and/or undersigned authorized Patient Representative.

Signature (mark one box below)	Date

I am ☐ patient ☐ patient's parent ☐ patient's legal guardian ☐ patient's legal representative

_____ _____

Signature (Porch Light Psychology, Inc.) Date