RELEASE OF INFORMATION

I, _____(Client Name), whose Date of Birth is _____, authorize Tracy E. Hill, Ph.D. & Associates LLC | Center Street Center | MCES | CCES to disclose to and/or obtain from:

_____ _____

Person/Title/Organization Email/fax/phone

The following information:

☐ Psychological/social evaluation	☐ Educational Records	☐ Psychiatric evaluation
☐ Medical information	☐ Legal information	☐ Custody/conciliation records
☐ Treatment plan/summary	☐ Admission/discharge	☐ Current treatment update
☐ Medication management info	☐ Assessment/Diagnosis	☐ _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Tracy E. Hill, Ph.D. at Center Street Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

This release shall remain in effect for one year subsequent to its signing or until rescinded in writing.

I understand that Center Street Center will not condition my treatment on whether I give authorization for the requested disclosure. However, I understand that failure to sign this authorization may limit the information needed to provide a full assessment/diagnosis/counseling/evaluation/etc.

Unless I have specifically requested in writing that the disclosure be made in a certain format, Center Street Center reserves the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper or electronic formats. I further understand that information released under this Release of Information authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to the privacy protections provided to me by law.

This form has been explained to me and I understand its content.

_____

Signature of client, if 14 years or older DATE

_____

Signature of custodial parent of client under 14 yrs. of age DATE

_____

Signature of Witness if refusal to sign authorization DATE

If you are the legal representative of the person listed above, please check the basis for your authority.

□ Power of Attorney (attach copy) □ Guardianship Order (attach copy) □ Attorney □ Healthcare surrogate, etc.