THE FAMILY PSYCHOLOGICAL CENTER, P.A.
CHARLES NICHOLS, PSY.D.
623 North Walnut St., Harrison, AR 72601
PH: (870) 743-6225; FX: (870) 743-6006

CONSENT AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION AND MEDICAL RECORDS

Patient: _____ DOB: _____ SS# _____

I grant permission for ____ RELEASE ____EXCHANGE of information relating to ____MY CARE ____ MY CHILD'S CARE regarding the parties named.
(CHECK ONE) (CHECK ONE)

TO: _____ FROM: **The Family Psychological Center, P.A.**
Name or Agency or Individual
_____ **623 North Walnut St.**
Address
_____ **Harrison, Arkansas 72601**
City, State, Zip Code

Concerning my right to confidentiality, I hereby authorize the release of the following specific information under the protection of FEDERAL LAW, TITLE 42, CP PART 2, as it relates to alcohol and drug information.

YES	NO	(CHECK ALL ITEMS)
____	____	1. Medical history, examination, lab tests, treatment reports
____	____	2. Psychiatric evaluation reports
____	____	3. Psychological test reports
____	____	4. Social history (intake assessment) i.e. to include presenting problems, family, education, employment, alcohol or drug, legal/arrests, medical, medications, allergies/drug reactions, emotional/psychological, and living skills
____	____	5. Alcohol and drug use treatment i.e., attendance, participation, urine drug screen, diagnosis and summary
____	____	6. Periodic reports of progress in treatment and treatment plan
____	____	7. HIV/AIDS information
____	____	8. Other (Specify): _____

I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSES:

YES	NO	(CHECK ALL ITEMS)
____	____	1. To develop a diagnosis, treatment, and/or rehabilitation
____	____	2. To coordinate a medical, psychological, and social rehabilitative process
____	____	3. Other (Specify): _____

I understand that I may revoke this consent to release of information at any time. However, I also understand that any release which has been made before my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when treatment at The Family Psychological Center, P.A. is terminated (State expiration of release) _____. At this time, no express revocation shall be needed to terminate my consent. The requested information will be used for my continued treatment.

- This consent for release of information is given freely, voluntarily, and without coercion.
- I understand that a copy or facsimile of this release of information shall be accepted as valid.

_____ _____ _____ _____
SIGNATURE OF CLIENT DATE SIGNATURE OF STAFF MEMBER/WITNESS DATE

_____ _____
PARENT OR LEGAL GUARDIAN DATE

Office Use Only: ____ ***File Release***
____ ***Request Information***
____ ***Send Out Information***

NOTE TO PROGRAM RECEIVING THIS INFORMATION:
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED. STATUTES/REGULATIONS PROHIBIT YOU FROM MAKING FURTHER DISCLOSURE WITHOUT THE SPECIFIC WRITTEN CONSENT FROM THE PERSON TO WHOM IT PERTAINS, OR OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.