RELEASE OF INFORMATION
Authorization Form

This form, when completed and signed, authorizes Hope Psychology Practice, LLC to release or obtain protected health information from your clinical records, including records created after the date of your signature.

Client's Name: _____ DOB: _____

I authorize Dr._____ to:

□ Disclose Information To
□ Receive Information From
□ **Exchange Information With**

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

To exchange the following information:

□ Summary of History / Diagnostic Interview
□ Discharge Summary and Diagnosis
□ Reports of Psychological Testing
□ Clinical Impressions and Behavioral Observations
□ Educational Records
□ **All Health Information**
□ Other: _____

The purpose of the disclosure is to facilitate:

□ Continuation of Care
□ Evaluation
□ School
□ Legal Issues
□ Insurance Claim
□ Other: _____

Release method:

□ Verbal Communication
□ Email
□ Fax
□ **All Communication Methods**

This authorization shall remain in effect for one year past the date of signature. You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address or by signing below. However, your revocation will not apply to information already released in response to this authorization. Furthermore, if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim, your revocation will not be effective. *Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.*

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Parent/Legal Guardian Relationship Date

Sign / Date Here to Revoke Authorization: