Doray Psychological Services, P.L.L.C.

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Authorization for Release of Information

This document is to be completed and signed by the client or client's legally authorized representative. For the purpose of this document, a client's legally authorized representative is someone who has the **legal authority to make health care decisions for him or her** (for example, a parent or legal guardian of a child under 18, a DHS caseworker of a child under 18 in DHS custody, a family member who has legal guardianship or health care power of attorney for an adult 18 or older). Adults 18 and older generally have the legal authority to make health care decisions for themselves, while children and adolescents under 18 generally do not. No one can make such decisions on behalf of another person unless they have the legal authority to do so.

Client Name: _____ Date of Birth: _____

I hereby authorize Doray Psychological Services, P.L.L.C. to:

☐ Release information to: ☐ Obtain information from:

Name:
Address:
Phone:
Fax:

Dates covered by request: _____ to _____

Purpose of request: ☐ School Related ☐ Court Related ☐ Coordination/Continuity of Care

☐ Patient Request ☐ Other: _____

The specific information to be requested or released is indicated by my initials below:

_____ Diagnostic Evaluation
_____ Psychological Evaluation/Testing
_____ Treatment Plans
_____ Progress Notes
_____ Discharge/Treatment Summary
_____ School Observations
_____ Verbal Progress Reports
_____ Entire Health Care Record
_____ Other: _____

A photocopy or faxed copy of this signed authorization shall constitute a valid authorization. I certify that this authorization has been given voluntarily and without coercion. I agree that all blanks in this form are properly filled in prior to my signature.

I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature or 90 days after termination of services, whichever is later.

Unless the purpose of this authorization is to determine payment of a claim or benefits, Doray Psychological Services, P.L.L.C. may not condition the provision of services or payment for my care on my signing this authorization.

Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws and regulations. The information authorized for release may include protected health information related to mental health.

I understand that Doray Psychological Services, P.L.L.C. may charge a reasonable, cost-based fee for copies of health care records that includes the cost of copying, cost of supplies, labor of copying, and postage, if applicable, and will not charge more than is allowed by law.

I represent that I am authorized by law to act on behalf of the client identified above.

I understand and agree to the statements above.

_____ _____

Signature of Client Date

_____

Printed Name of Client

_____ _____

Signature of Client's Legally Authorized Representative Date

_____

Printed Name of Client's Legally Authorized Representative

_____

Relationship of Legally Authorized Representative to Client