Consent for Release of Information

I_____, hereby authorize _____ to
(your name) (your therapist's name)

(check all that apply):

__ Exchange with __Release to __Obtain from
information regarding my record.

Agency/Person's Name_____
Address_____
Phone_____Fax_____

The following information may be exchanged (check all that apply):

- o All Treatment Records
- o All Medical Records
- o Substance Use/Abuse History and Treatment (if applicable)
- o Psychotherapy Notes
- o Intake Summary
- o Discharge Summary
- o Psychological Testing
- o General Information Related to Treatment Progress
- o Other (please specify)_____

Reason for Release of Information: o Continuity of Care
o Other _____

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
One year from patient signature on this form

(Specification of the date, event or condition upon which this consent expires)

I understand that I may request a copy of this authorization. I understand that to revoke this authorization, I must provide a written request to Kristen Aycock, Ph.D.

Dated: _____ _____
Signature of patient (or guardian/authorized representative when required)