Request And Authorization to Release Confidential Information

I, the undersigned, hereby request the release of confidential information and grant authorization for the release of confidential information regarding the following patient, including personal, mental health, chemical dependency, or medical history, findings, opinions, diagnoses, services rendered, and prognoses, ☐ except for _____.
☐ with no exceptions.

Patient's Name	Date of Birth	Social Security Number	Approximate Date(s) of Treatment

☐ Released by
☐ Furnished to
☐ Both

James J. De Santis, Ph.D.
Clinical Psychology
Post Office Box 894
Glendora, CA 91740-0894
(818) 551-1714

☐ Released by
☐ Furnished to
☐ Both

_____

_____

_____

_____

Information requested is the following:

☐ Pertinent summary
☐ Medical history & exam results
☐ Psychiatric evaluation results
☐ Psychological test results
☐ Complete patient record
☐ Other (specify): _____

☐ Psychosocial history
☐ Consultation reports
☐ Diagnostic impressions
☐ Course of treatment
☐ Billing records

☐ Progress/process notes
☐ Discharge summary
☐ Dates of service
☐ School or work performance

This information is for the purpose of:

☐ Evaluation
☐ Treatment Planning
☐ Forensic Service
☐ Other (specify): _____

☐ Continuity of care
☐ Consultation
☐ Disability Evaluation

☐ Referral
☐ Insurance reimbursement
☐ Subpoena

This authorization shall be effective immediately. A photocopy of this authorization shall be considered as valid as the original. Information may be released orally, in writing, or by photocopy. Information disclosure may be in person, by telephone, mail, e-mail, or facsimile.

I understand that I have no obligation to consent to release of information, that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, in which event information cannot and will not be released, unless otherwise required by law.

I understand the recipients of information are prohibited by law from making any further disclosure to third parties unless expressly permitted by additional written consent or otherwise required by law.

I understand that I can revoke my consent at any time in writing, except to the extent that action has already been taken in reliance upon my consent. If not earlier expressly revoked, this authorization will remain in effect until six months after service is terminated.

I agree to hold harmless those authorized above, and their agents, designees, and representatives from any and all liability arising from the release of information to the person(s)/agency(ies) designated above, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I understand that I have a right to receive a copy of this authorization upon my request. A copy of this form has been requested and received: ☐ Yes ☐ No

I, the undersigned, am: ☐ the above-named patient, ☐ the parent or legal representative of the above-named minor patient, ☐ the beneficiary or personal representative of the above-named patient who is deceased.

I have read, understood, and agreed to the above conditions. I have clarified any questions before signing. I hereby grant my consent.

Patient, Parent, or Responsible Person Signature	Printed Name	Relationship, if other than patient	Date