

# Powers Ferry Psychological Associates, L.L.C.

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## Release of Information

I hereby authorize \_\_\_\_\_ (Therapist's name)

to:     release     receive     exchange

information concerning \_\_\_\_\_ (Name of Patient, DOB)

to             from             with \_\_\_\_\_ .

I understand that such disclosure will be made for the following purposes:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Treatment Progress       | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Child Custody / Visitation |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Social History         | <input type="checkbox"/> Competency to stand trial  |
| <input type="checkbox"/> Medical Treatment        | <input type="checkbox"/> Treatment Summary      | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Academic Placement       | <input type="checkbox"/> Diagnosis              | _____   |

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and, if not earlier revoked, it shall terminate on \_\_\_\_\_ without revocation.

I understand that disclosures may not be subject to confidentiality if the therapist becomes aware of any suicidal or homicidal thoughts or plans, or in the event that the therapist becomes aware of any form of abuse or neglect.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

\_\_\_\_\_ I authorize this information to be faxed to the party indicated above, and understand the limits of  
Initial confidentiality which doing so creates.

\_\_\_\_\_  
Signature of patient, parent, or legal guardian

\_\_\_\_\_  
date