RPS | REED PSYCHO_OGICAL SERVICES

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

First Name _____ Middle Name _____ Last Name _____

Date of birth ___/___/_____ Home Address _____

City _____ State _____ Zip code _____

Phone number _____ Email address _____

I (*client name*) _____, hereby authorize ***Reed Psychological Services*** to:

_____ disclose to _____ obtain from _____ exchange with

Name of person/agency _____

Address of person/agency _____

Phone number _____ Fax number _____

The following information:

____ Client profile/history

____ Dates of treatment attendance

____ Discharge/treatment summary

____ Billing & financial information

____ Evaluation/testing results

____ Progress notes

____ Diagnostic information

____ Mental health reports

____ Substance abuse reports

____ Physical/Medical/Medications

____ Legal/Court records

____ Other (specify): _____

Regarding services provided during dates/years of treatment (approximate dates) _____

I understand that I have the right to refuse to sign this authorization. I understand that by signing this form, I am requesting that my health information be sent to the third party specified above. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named above. If the organization, facility or professional 3 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when my health information is sent to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Reed Psychological Services will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

Client/Legal representative: _____ Date: _____