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AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Information Authorized: □ Dates of Attendance □ Clinical Summary
□ Psychological Evaluation Results □ Other (specify): _____

Purpose of Release/Exchange: □ Treatment Planning □ Educational
□ Client's/Authorized Representative's Request □ Other (specify): _____

Persons/organizations releasing/exchanging information:

Name: _____ Title/Relationship: _____
Address: _____ Phone: _____
_____ Fax: _____

I authorize Emily C. Engel, PsyD, to release and/or exchange protected health information from my clinical record. I understand the following points:

- Authorizing the disclosure of this private health information is voluntary and I may refuse to sign the authorization.
- If the person or organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations.
- This authorization will expire on _____ (date) or within 1 year of the date of this request.
- I may revoke this authorization at any time by notifying Emily C. Engel, PsyD, in writing. That revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient

_____ _____
Witness Signature Date

Form Revised 10.17.17