BEHAVIORAL
PSYCH
STUDIO

www.behavioralpsychstudio.com
info@behavioralpsychstudio.com
(917) 497-2760

Authorization for Release of Information

I, _____, hereby authorize Behavioral Psych Studio and
(Client)

_____, at _____ to exchange information.
(Name) (Telephone)

The type of information to be disclosed:

Evaluations _____	Psychological/Medical Test Results_____	Psychotherapy Notes _____
Treatment Plan_____	Medical/Hospital Records_____	Course of Treatment_____
Diagnosis _____	Mental Health Record Summary_____	Other _____

The purpose of such disclosure:

Ongoing Treatment_____	Medical Care_____	Consultation_____
Evaluation_____	Transfer_____	Legal issues_____
Coordination of Care_____	Other _____	

Exceptions:_____ ‘

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Behavioral Psych Studio and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect until_____.

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

BEHAVIORAL
PSYCH
STUDIO

www.behavioralpsychstudio.com
info@behavioralpsychstudio.com
(917) 497-2760

Date

Signature of Client or Personal Representative