

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Patient DOB: _____

I _____, hereby authorize:

Patricia Beldotti, PsyD
7618 N La Cholla Blvd., Tucson, AZ 85741
Tel: 520-404-7553, Fax: 520-334-2006

To release the following information in my/my child's records:

- Neuropsychological Evaluation Report
- Psychological Evaluation Report
- Brief summary that evaluation was completed, diagnoses, and recommendations
- Phone call discussion about clinical impression & recommendations
- Other: _____

This information is to be released to (copy this form to send to more than one person):

Name of Person & Company: _____

Tel: _____ Fax: _____

Full Mailing Address: _____

This information is to be released for the following purpose(s):

- Treatment planning & coordination of care
- Other: _____

I understand that I have the right to revoke consent to future disclosure in writing at any time, however this revocation will not be effective to the extent that I have already taken action in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment generally may not be conditioned on signing a release of information, unless the services are provided to me for the purpose of providing information to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA privacy rule. I acknowledge that I have had the opportunity to discuss and ask questions about issues concerning privacy and confidentiality and this consent.

This is authorization will remain in effect until _____ unless otherwise revoked in writing at a future point in time.

Signature of Patient or Parent/Guardian

Date

Printed Name of Patient or Parent/Guardian