AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ Patient DOB: ___________________________

I ____, hereby authorize:

NAME: ____

ADDRESS: ____

TEL: _____________________________________ FAX: _______________________________

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

☐ Summary of presenting problems, diagnoses, and recommendations
☐ Psychological Evaluation Reports
☐ Progress Notes
☐ Other: ____

This information is to be released to:

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

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

☐ for completion of a psychological / neuropsychological evaluation

☐ 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