CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

**I authorize Kristin Rose, PsyD to** (check one or both below)**:**

**\_\_\_\_\_\_\_\_release the information checked below**

**\_\_\_\_\_\_\_\_receive information checked below**

|  |  |
| --- | --- |
| \_\_\_\_\_Summary of Assessment and Treatment | \_\_\_\_\_Testing Report/Diagnostic Assessment |
| \_\_\_\_\_Diagnostic Impressions | \_\_\_\_\_Verbal Exchange: All Clinical Information |
| \_\_\_\_\_Notes of Clinical Record  |  \_\_\_\_\_Other: |
| \_\_\_\_\_School Records/IEP |  |

**for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Name)

**to/from:**

|  |  |
| --- | --- |
| Name/Agency: |  |
| Address: |  |
| Phone Number: |  |
| Fax: |  |

**For the purposes of** (check all that apply)**:**

\_\_\_\_\_ Treatment Planning \_\_\_\_\_ Coordination of Services

\_\_\_\_\_ Continuity of Care \_\_\_\_\_ Other

I am signing this consent under the following conditions:

 a. My judgment is neither impaired by emotional duress nor any chemicals.

b. I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken thereupon.

c. If not withdrawn, this authorization expires one year from the date below unless revoked in writing.

d. That upon expiration of this release neither agency nor practitioner will discuss information pertaining to me without my further consent except for communication with any insurance company which I have separately authorized.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian (if patient is a minor) Date