Child & Family Psychological Associates
822 Portage Trail, Cuyahoga Falls, OH 44221
330-923-9344/ 1-866-248-1103 (f)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Child & Family Psychological Associates to disclose and exchange the following information from the health records of:

Name: ____ DOB: ______________

Address: ____

Covering the period(s) of healthcare: From (date) ________ to (date) ____________

INFORMATION WHICH IS THE SUBJECT OF THIS RELEASE

______ Entire Record
______ Treatment Summary
______ Diagnostic Tests and/or Summary Thereof
______ Medical Records
______ Psychological Reports
______ Treatment/Discharge Summary
______ Progress Notes
______ Academic testing, grades & records
______ Legal/court records & police reports
______ Other ____________________________________

I understand that this will include information relating to (check if applicable):

____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

____ Psychiatric Care

_____ Treatment for alcohol and/or drug use

This information is to be disclosed to and exchanges with:

Name: ____

Address____

Phone: ______________________________ Fax: __________________________

For the purpose of: ____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 180 days for the authorized signature date. Child & Family Psychological Associates, its employees, officers and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____/______________
Signature of Client Date

IF CLIENT DOES NOT SIGN COMPLETE SECTION BELOW

________ Client is a minor

________ Other ______________________________

______________________/__________________________/______________
Signature of Parent~ Legal Guardian/Printed Name Date

______________________/__________________________/______________
Signature of Witness/Printed Name Date