Psychology and Beyond, LLC

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Consent for Release of Confidential Information

I, ______________________________________ ________________________________
Name Date of Birth

____
Street Address City State Zip Code

authorize ____

to release information to ____.

This authorization will cover only those records selected or written and the dates specified.

Diagnosis	Psychiatric Evaluation	Recommendations
Medication	Psychological Records	Results and Testing
Social History	Medical Records	School History & Records
Progress and Treatment	Reason for Termination	Psychotherapy Notes

Other ____

Dates Specified ____

This authorization is being signed for the purpose of ___________________________________

____

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. This consent will terminate upon ____
Date, Event, Condition

I understand I may revoke this consent at any time.

______________________________________ ___________________________________
Client Signature Date Signed

______________________________________ ___________________________________
Parent or Guardian Signature Date Signed

______________________________________ ___________________________________
Witness Signature Date Signed