Christian Psychological Center

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Consent and Authorization to Release/Exchange Information or Medical Records

I do hereby authorize the release/exchange of psychological/educational/medical information or records regarding me / my child(ren) (circle one)

_____ (_____),
(Name of Patient) D.O.B.

between _____
(Name of person/facility releasing information)

and _____.
(Name and address of person/facility receiving information)

Information to be released:

Treatment Summary ☐ Treatment Plan ☐ Prognosis ☐ Recommendations ☐
Attendance/Engagement ☐ Testing Reports ☐ Other: _____

The information is to be released for the purpose of: _____

_____.

I understand that I may revoke this consent of information at any time; however, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. If not previously revoked, this authorization shall expire upon: _____
(Date, event or condition)
or ninety (90) days from the date signed if no other date, event or condition for expiration is defined. At that time no express revocation shall be needed to terminate the consent.

_____ _____
Patient Signature (both signatures if it is couples counseling) Date

_____ _____
Witness Signature Date

_____ _____
Parent/Guardian Signature (If patient is either under age or has a guardian appointed by the court). Date

* Any substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.