Duluth Psychological Clinic

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____
(Last) (First) (Maiden or other)

Date of Birth: _____

Address: _____

_____

I authorize (Clinician): _____

to ___ exchange with ___ send to ___ receive from

Person or Organization: _____

Address: _____
(Address)

The following information:

( ) Psychological assessments
( ) Face-to-face or telephone conversations
( ) Psychotherapy notes
( ) Treatment or assessment summaries
( ) Other

( ) Diagnostic assessments
( ) Medical and psychiatric records
( ) Chemical dependency service records

_____

to coordinate care and facilitate my psychological treatment between the dates of _____

This authorization shall remain in effect for one year, or until _____ (whichever occurs first). I have the right to revoke this authorization at any time by sending written notification to the Duluth Psychological Clinic. However, my revocation will not be effective to the extent that the Duluth Psychological Clinic has relied upon 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 Clinician may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule. **A photocopy of this authorization may be treated in the same manner as the original.**

Signature of client or legal guardian: _____ Date: _____