

# Request And Authorization to Release Confidential Information

I, the undersigned, hereby request the release of confidential information and grant authorization for the release of confidential information regarding the following patient, including personal, mental health, chemical dependency, or medical history, findings, opinions, diagnoses, services rendered, and prognoses,  except for \_\_\_\_\_.  
 with no exceptions.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Approximate Date(s) of Treatment \_\_\_\_\_

Released by James J. De Santis, Ph.D.  Released by \_\_\_\_\_  
 Furnished to Clinical Psychology  Furnished to \_\_\_\_\_  
 Both 138 North Brand Boulevard, Suite 300  Both \_\_\_\_\_  
Glendale, CA 91203-4618  
(818) 551-1714 Voicemail

Information requested is the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pertinent summary              | <input type="checkbox"/> Psychosocial history   | <input type="checkbox"/> Progress/process notes     |
| <input type="checkbox"/> Medical history & exam results | <input type="checkbox"/> Consultation reports   | <input type="checkbox"/> Discharge summary          |
| <input type="checkbox"/> Psychiatric evaluation results | <input type="checkbox"/> Diagnostic impressions | <input type="checkbox"/> Dates of service           |
| <input type="checkbox"/> Psychological test results     | <input type="checkbox"/> Course of treatment    | <input type="checkbox"/> School or work performance |
| <input type="checkbox"/> Complete patient record        | <input type="checkbox"/> Billing records        |   |
| <input type="checkbox"/> Other (specify): _____         |   |   |

This information is for the purpose of:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Evaluation             | <input type="checkbox"/> Continuity of care    | <input type="checkbox"/> Referral                |
| <input type="checkbox"/> Treatment Planning     | <input type="checkbox"/> Consultation          | <input type="checkbox"/> Insurance reimbursement |
| <input type="checkbox"/> Forensic Service       | <input type="checkbox"/> Disability Evaluation | <input type="checkbox"/> Subpoena                |
| <input type="checkbox"/> Other (specify): _____ |  |  |

This authorization shall be effective immediately. A photocopy of this authorization shall be considered as valid as the original. Information may be released orally, in writing, or by photocopy. Information disclosure may be in person, by telephone, mail, e-mail, or facsimile.

I understand that I have no obligation to consent to release of information, that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, in which event information cannot and will not be released, unless otherwise required by law.

I understand the recipients of information are prohibited by law from making any further disclosure to third parties unless expressly permitted by additional written consent or otherwise required by law.

I understand that I can revoke my consent at any time in writing, except to the extent that action has already been taken in reliance upon my consent. If not earlier expressly revoked, this authorization will remain in effect until six months after service is terminated.

I agree to hold harmless those authorized above, and their agents, designees, and representatives from any and all liability arising from the release of information to the person(s)/agency(ies) designated above, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I understand that I have a right to receive a copy of this authorization upon my request. A copy of this form has been requested and received:  Yes  No

I, the undersigned, am:  the above-named patient,  the parent or legal representative of the above-named minor patient,  the beneficiary or personal representative of the above-named patient who is deceased.

*I have read, understood, and agreed to the above conditions. I have clarified any questions before signing. I hereby grant my consent.*

\_\_\_\_\_  
Patient, Parent, or Responsible Person Signature      Printed Name      Relationship, if other than patient      Date