CHC PSYCHOLOGICAL SERVICES CLINIC

Authorization for Release of Confidential Information

CLIENT'S FULL NAME:_____

I HEREBY AUTHORIZE THE **CHC PSYCHOLOGICAL SERVICES CLINIC, 1107 Bethlehem Pike, Suite 212, Philadelphia, PA 19031** TO DISCLOSE TO / RECEIVE INFORMATION FROM (circle one or both):

_____

Insert the identity, name, or class of persons to whom information will be disclosed.

_____

Insert the COMPLETE address and telephone number of the person(s) to whom information will be disclosed.

I UNDERSTAND THAT THIS INFORMATION DISCLOSURE / RELEASE WILL BE MADE FOR THE FOLLOWING PURPOSES:

□ Assessment/Evaluation

AND WILL BE LIMITED TO THE FOLLOWING SPECIFIC TYPES OF INFORMATION (circle all that apply):

□ Oral discussion	□ Complete Written Record	□ Session attendance
□ Billing/payment records	□ Case Notes	□ Diagnostic Information
□ Intake Evaluation Report	□ Assessment/Evaluation Reports	□ Substance Abuse
□ Intake Summary	□ Treatment Plans/Reviews	□ Termination/Transfer Summaries
□ Summary of Record Only	□ Other:_____	

THIS INCLUDES INFORMATION FROM _____ TO _____.
(Date) **(Date)**

This authorization will expire on:

- □ Six months from date signed below.
- □ Event: _____
- □ Other date: _____

- I HEREBY AUTHORIZE THE RELEASE OF THE ABOVE INFORMATION FROM MY / TO MY CHILD'S (circle one or both) RECORD.
- I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION, AND THAT I HAVE THE RIGHT TO REVOKE MY PERMISSION TO RELEASE THIS INFORMATION BEFORE IT IS RELEASED.
- UNDERSTAND THAT THIS INFORMATION IS CONFIDENTIAL AND IS PROTECTED WITHIN THE BOUNDS OF LAW FROM DISCLOSURE WITHOUT MY PERMISSION.
- I FURTHER UNDERSTAND THAT RELEASED INFORMATION MAY BE SUBJECT TO REDISCLOSURE AND MAY THEN NO LONGER BE PROTECTED.

_____ _____

CLIENT OR LEGAL GUARDIAN'S SIGNATURE **DATE**

RELATIONSHIP TO CLIENT:_____

_____ _____

SIGNATURE OF PERSON INFORMING CLIENT OF RIGHTS **DATE**

_____ **Check here to indicate copy has been given to the client**