**AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION**

This form, when completed and signed, authorizes Dr. Allison Solomon, Psy.D, PLLC to release, request, or exchange protected health information from the patient’s clinical record to the person or agency designated below.

Name of Patient:            Date of Birth:

**I hereby give consent to Dr. Allison Solomon to exchange pertinent and relevant information with the individual/agency identified below:**

Name:            Address:

Phone:            Fax/Email:

**I hereby authorize Dr. Allison Solomon, Psy.D, PLLC to release, request, or exchange the following information:**

*Please put a check mark (✓) next to your selections (check all that apply)*

[ ]  Phone Contact/Verbal Communication

[ ]  Written Communication and Coordination

[ ]  Fax (If records are inadvertently received by an unauthorized recipient, through no fault of the sender, I waive claim against the sender)

[ ]  E-mail (If information is inadvertently received by an unauthorized recipient, through no fault of the sender, I waive claim against the sender)

[ ]  ALL Protected Health Information (PHI) and Financial Information

[ ]  ALL Psychological and Psychiatric: Evaluation reports, test results, letters

[ ]  Medical (Evaluation, Progress Notes, Lab Results, Treatment Reports, etc.)

[ ]  Academic (School personnel contact, Report Cards, Test Results, Evaluation Results, Teacher contact, Behavior Observations etc.)

[ ]  Psychological testing results

*[ ]  Psychotherapy Notes* (This box must be *specifically checked* due to additional regulations regarding the protection of these records)

[ ]  Other (Specify):

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* I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
* I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that this information may be re-disclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. I have been informed what information will be given, its purpose, and who will receive the information.
* I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. By my signature below, I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Dr. Solomon has already used or disclosed the information in reliance to this authorization. This authorization will expire only upon completion of a consent revocation form.

**Signature of Patient/Parent/Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**