

Authorization Form

This form when completed and signed by you, authorizes me to release confidential information from your clinical record to the person you designate.

You authorize CTY's Diagnostic and Counseling Center to release:

This information should be released only to _____ Department at CTY.

You are requesting that I release this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

If checked, you are requesting that the information to be released includes medical records information received from another provider. You understand that I cannot redisclose information received from another health care provider if that health care provider requested that the information not be redisclosed.

This authorization shall remain in effect until _____ (may not exceed one year).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the psychologist/diagnostician identified above. However, your revocation will not be effective to the extent that I have taken action in reliance on the 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.

You understand that I generally may not deny services based on your unwillingness to sign an authorization unless the psychological services are provided to you for the purpose of creating health information for a third party.

Signature

Date