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Request/Authorization for Release of Confidential Records and/or Information

This forms allows your clinician to communicate with other key professionals. I hereby authorize:

Name/Facility: _____

Address: _____

Phone number: _____

Email Address: _____

To **obtain/release** (circle one or both) the records/information about:

If you circle obtain, VPA can receive information about the patient named below. If you circle release, then VPA can release information to the person named above. If you circle both, then both parties can release and discuss information about the patient named below.

Patient Name: _____ **Date of Birth:** _____

To the provider, _____, at Vorpahl Psychology Associates for the purpose(s) of:

_____ Further mental health evaluation, treatment, or care

_____ Treatment Planning and coordination of care

_____ Education planning

_____ Other: _____

Information should be sent to the postal address/fax/email/phone number in the letterhead at the top of this form

I have had it explained to me and fully understand that this request/authorization to release records and information, including the entire nature of the records, their content, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this consent at any time within 90 days, except to the extent that action based on this consent has already been taken.

_____ _____
Signature of patient/parent/guardian/representative Date

_____
Printed name of signatory above/Relationship to patient