Authorization for Release of Information

I, _____, authorize Delta Psychology Center to exchange information with:

_____

_____

_____

This authorization concerns clinical information regarding _____.

The purpose for the release of information is for:

- ❑ *Coordination of psychological and medical care*
- ❑ *Legal proceedings*
- ❑ *Insurance purposes*
- ❑ *Other* _____

The information to be released involves:

- ❑ *Treatment summary and recommendations*
- ❑ *Results of a formal psychological evaluation*
- ❑ *Information necessary for completion of insurance forms*
- ❑ *Other* _____

I understand that my permission to disclose information is voluntary and that I do have the right to decline my permission. I also understand that I have a right to view or copy the information to be disclosed. I understand that it is possible that this information could be re-disclosed by the party to whom this information is released.

This Authorization is valid for one year from the date of the signature below unless I choose to revoke it at an earlier date in writing.

_____
Signature of Patient

_____
Signature of Parent/Guardian if patient is a minor

_____
Date

_____
Signature of Witness

_____
Date