



**SOUTH COUNTY
PSYCHOLOGICAL, INC.**
Finding solutions and feeling better.

Authorization for Release of Client Information

Client's Name: _____ Date of Birth: ___/___/___

Address: _____

Telephone Number: (____) _____ Email: _____

I give permission and authorize **Susan J. Novak, PhD** at South County Psychological, Inc., 23832 Rockfield Blvd, Suite 150, Lake Forest, CA 92630 to
 ___ release information to: ___ obtain information from: X exchange information with:

Name: Blue Cross Blue Shield

Address: _____

Phone Number: (____) _____ Email: _____

Relationship to Patient: pt's insurance company

Note: Fees may apply to consents that require information to be copied and/or mailed.

Purpose: The information disclosed may only be used for the following purpose(s): billing and insurance

Nature of Information Provided:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Summary of Treatment | <input type="checkbox"/> Only Confirm Enrolled in Treatment |
| <input type="checkbox"/> Psychological Testing Results | <input checked="" type="checkbox"/> Confirm Dates of Visits |
| <input type="checkbox"/> Evaluation Reports | <input checked="" type="checkbox"/> Diagnosis & Treatment Details |
| <input checked="" type="checkbox"/> Treatment Reports | <input checked="" type="checkbox"/> Progress Reports |
| <input type="checkbox"/> Copies of Medical Records/X-rays/Tests | <input type="checkbox"/> Complete Attached Form |
| <input type="checkbox"/> Psychiatric Evaluation and Treatment | <input checked="" type="checkbox"/> History and Current Functioning |
| <input type="checkbox"/> Confirm, Schedule and Cancel Appointments | |
| <input type="checkbox"/> Other: _____ | |

Type of Information:

- Mental Health dated from _____ to treatment end Initials _____
- Alcohol/Drug dated from _____ to _____ Initials _____
- Medical dated from _____ to _____ Initials _____
- Other: _____ from _____ to _____ Initials _____

Duration of Authorization: This authorization shall remain in effect for:

One year from the signature date One time contact
 Until this treatment episode ends Until this disability/legal case is concluded
 Other: _____

Revocation: You or your representative can revoke this authorization at any time. If you revoke this authorization, any information disclosed or received prior to you notifying South County Psychological, Inc. of your wish to revoke this authorization shall not constitute a breach of confidentiality.

Redisclosure: Once this information is disclosed, how the recipient further discloses or uses the information may no longer be protected under federal privacy law (HIPAA) or confidentiality laws.

Free to Consent: You are signing this release freely. There are no adverse consequences to the treatment you receive from South County Psychological, Inc. for choosing not to sign this release, or if you later choose to revoke this release. If you are using insurance to pay for your treatment, or have a disability, a legal, or a medical case which needs mental health information, your choice not to allow South County Psychological, Inc. to share information may or may not affect those insurance, treatment, legal, or medical issues.

A copy of this authorization is as valid as an original. I have the right to receive a free copy of this authorization.

I, the undersigned, have read this authorization prior to signing it, fully understand the nature of this release, and freely give my consent to release the information as described above.

_____	_____
Client's Signature	Date

Printed Name	
_____	_____
If Client is a Minor, Parent's or Guardian's Signature	Date
_____	_____
Witness' Signature	Date

To recipient of release: The information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient.