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: Medicare _____

Address: _____

Phone Number: (____)_____ Email: _____

Relationship to Patient: client'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:

_X_ Summary of Treatment	_____ Only Confirm Enrolled in Treatment
_____ Psychological Testing Results	_X_ Confirm Dates of Visits
_____ Evaluation Reports	_X_ Diagnosis & Treatment Details
_x_ Treatment Reports	_X_ Progress Reports
_____ Copies of Medical Records/X-rays/Tests	_____ Complete Attached Form
_____ Psychiatric Evaluation and Treatment	_X_ History and Current Functioning
_____ Confirm, Schedule and Cancel Appointments	

_____ Other: _____

Type of Information:

_X_ Mental Health dated from _____ to treatment end _____ Initials _____
_____Alchohol/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

_X___ 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 rultes restrict any use of the information to criminally prosecute any alcohol or drug abuse patient.