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: ____exchange information with:

Name: ____

Address: ____

Phone Number: (____)_______________________ Email: ______________________________

Relationship to Patient: ____

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): _________
____

Nature of Information Provided:

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

Type of Information:

_____ Mental Health dated from __________________ to ________________ 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

_____ 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.

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