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CONFIDENTIAL AUTHORIZATION TO RELEASE INFORMATION FORM

I, _____, do hereby authorize Kristen Herzel, Ph.D., to RELEASE TO

and/or OBTAIN FROM (circle) _____

Information from the record of _____.

The reason for this release is: To provide clinical and educational information for neuropsychological evaluation.

Name: _____ DOB: _____

The information I authorize to be released to and/or obtained from the agency or person listed above is limited to the following: (Please itemize portions of the record, and time periods if applicable, from the following list)

_____ Biopsychosocial evaluation
_____ Summary of treatment to date
_____ Diagnostic impressions
_____ Medication record
_____ Medical examination (blood/lab tests)
_____ Progress notes
_____ Attendance in treatment
_____ Treatment plan
_____ Urinalysis testing

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose (s) specified above. I have been informed of my rights (under law), and I understand the nature of this authorization to release information subject to Section III of the Mental Health Procedures Act 50 P.S. Section 7III, and the Regulations (Setion 5100.31, 5100.33, 5100.34) pursuant to said Act by the Commonwealth of Pennsylvania. I also understand that my records are protected under the Federal Privacy Act (P.L. 93-575), the Federal HIPAA Administrative Simplification Provisions 45 CFR Part 160 and 164, the Federal Alcohol and Drug Abuse Act (P.L. 92-282), and the Pennsylvania Drug and Alcohol Abuse Act. I understand that it is possible that information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and no longer may be subject to privacy protections provided by law. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon). Finally, I understand that Kristen Herzel, Ph.D. may not condition my treatment on obtaining this authorization from me, except if the purpose of the treatment is to obtain information to be disclosed to a third party pursuant to the Authorization (i.e. health report that I want disclosed to an employer), or if this Authorization is for a research purpose, and treatment is involved. This authorization is effective for 90 days, unless otherwise specified.

EFFECTIVE DATE OF THIS RELEASE: _____ TO EXPIRATION DATE OF RELEASE: _____

_____ _____ _____
Signature of Client (Age 14 years or older) **Date** **Parent/Guardian Signature (14 or younger)**

_____ _____
Signature of Witness: Kristen Herzel, Ph.D. **Date**

[ ] I have chosen to receive a copy of this form **[ ] I have chosen not to receive a copy of this form**

In accordance with Federal Regulations (42 CFR Part 2 and 45 CFR Part 160 and 164) and Pennsylvania State Regulations: This information has been/ is being disclosed to you from records whose confidentiality is protected by Federal and State Law. Regulations limit our/ your right to make any further disclosure ont his information without the prior 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 investigate or prosecute any alcohol or drug abuse patient.