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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, date of birth _____, hereby authorize Susan Clemons, Ph.D., to release confidential information to:

_____
_____ Chart #:_____
_____

I authorize the following information to be released:

- ❑ Psychological evaluation
- ❑ Treatment summary
- ❑ Psychotherapy notes
- ❑ Billing records
- ❑ Other: _____

This authorization to release information is for the following purpose(s):

- ❑ Diagnosis and evaluation
- ❑ Treatment planning and continuity of care
- ❑ Processing of financial arrangements
- ❑ Other: _____

This authorization includes release of records related to:

- ❑ Diagnosis and/or treatment for alcohol and/or drug abuse
- ❑ HIV- and/or AIDS-related diagnosis and/or treatment

This authorization will remain effective for **365 days** from the date of signing. I understand that I can revoke this authorization in writing at any time prior to the release of information specified above. I understand that if the person or organization that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I also understand the following (a) I may refuse to sign this authorization; (b) I may inspect and obtain a copy of the health information that is described in this authorization; and (c) I will receive a copy of this signed authorization, IF I WANT ONE. I have reviewed this authorization and understand it.

_____ _____ _____
Printed name of patient or personal representative Signature Date

_____
Telephone number