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AUTHORIZATION FOR RELEASE OF INFORMATION

To(Name and Contact Information):

_____

_____

_____

RE: _____

DOB: _____

SSN: _____

I _____ authorize Angela Wozniak Minor, Ph.D, to release to **and/or** furnish the following information from my records to the above named person, firm, physician, clinic, school, hospital, or social agency:

_____Intake Summary, Termination Summary
_____Psychological Assessment, Psychological Test Data
_____Treatment Status, Progress Summary
_____Physical Examination and/or other Medical Data
_____School Records, School Performance, School Testing
_____Other_____

I hereby release the above named party from any liability for information furnished pursuant to this authorization. This release remains valid for the duration of the treatment period, if not specifically invalidated earlier, of the above named patient and copies and/or faxes of this authorization will be considered as valid as the original.

The purpose of this disclosure is:

_____To complete evaluation and facilitate treatment
_____Referral to another agency/treatment center
_____Other_____

THIS CONSENT TO DISCLOSE INFORMATION FROM MY RECORD MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME UNLESS THE INFORMATION HAS ALREADY BEEN RELEASED. THIS CONSENT REMAINS VALID FOR ONE YEAR FROM THE DATE OF MY SIGNING.
PROHIBITION OF REDISCLOSURE: THIS INFORMATION IS CONFIDENTIAL AND PROTECTED BY FEDERAL LAW 42 CFH PART 2 WHICH PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

_____PATIENT SIGNATURE _____WITNESS

_____PARENT/GUARDIAN SIGNATURE _____DATE