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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize Rachel Barbanel-Fried, Psy.D., to release information from records about (your name)_____________________ , born on _____________ , for the following purpose(s):

__ Further mental health evaluation, treatment, or care
__ Rehabilitation program development or services
__ Treatment planning
Other: __________________________________.
These records concern the time between ___________ and ____________ .

I authorize Rachel Barbanel-Fried, PsyD to obtain/supply information from/to: (name and contact information of coordinating clinician or person with whom information is to be shared)

__________________________________.

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them.
__ Intake/discharge summaries
__ Medical history and evaluation
__ Clinical evaluation
__ Psychological testing and assessment

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that received this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Name of Patient: ____

Signature of Patient: ____

Date: ____________________

I will provide you with a copy for your records if requested. Thank you.