ANCHOR POINT PSYCHOLOGICAL SERVICES LLC

RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I authorize Anchor Point Psychological Services to: ☐ Send ☐ Receive

The following information:

☐ Diagnostic/Intake Evaluation & Diagnosis
☐ Treatment Plan/Treatment Goals
☐ Mental Health Treatment Records
☐ Medical History & Evaluation
☐ Educational Records
☐ Discharge Summary
☐ Other: _____

To/From: _____ Phone: _____

The nature of the information released: ☐ Verbal ☐ Written

The above information will be used for the following purpose: _____

_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

_____ _____
Printed Name Date

_____
Signature
Relationship to client: ☐ Self ☐ Parent ☐ Legal Guardian

_____
Witness

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