

RELEASE OF INFORMATION AUTHORIZATION FORM

This form when completed and signed by you, authorizes Bethlehem Counseling Associates, P.C. to release protected information from your clinical record to the person you designate.

I/We _____ do hereby consent and
(Client Name)

authorize _____
(Therapist Name)

___ to release information to: _____ to secure information from:

Name _____

Agency/Doctor's Office _____

Address _____

City _____ **State** _____ **ZIP** _____

Phone _____ **FAX** _____

For the purpose of ___ treatment planning
___ other _____

The information to be released is:

___ Treatment Plan	___ Termination Summary
___ Psychological Evaluation	___ School Records
___ Progress Reports	___ Recommendations

Other (Please Specify) _____

I/We understand that this authorization shall remain in effect for **90 days** unless otherwise noted.
I/We also understand that this authorization can be revoked (except to the extent that action has been taken) at any time by dated, written communication to Bethlehem Counseling Associates, P.C.

I/We understand that BCA generally may not make the signing an authorization for a third party a condition of providing continued psychological services.

I/We understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Client _____
Date

Signature of Parent/Guardian or Authorized Representative _____
Date

Signature of Witness _____
Date