



Stein Psychological Associates, Inc.

assessment • therapy • consultation

AUTHORIZATION TO RELEASE CLIENT RECORDS

I, the undersigned, hereby request and authorize:

To disclose and/or receive information and records from:

Person/ School / Organization Receiving Information

Address

Phone, Fax and Email

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol related treatment, personal and family information, and delinquent and/or adult criminal history. Additionally, results from psychological testing may also be released. It may also contain related medical information, including test results from medical laboratories.

The disclosure of records and information authorized herein is required for the purpose of completing a comprehensive evaluation.

I specifically request that the following information be released:

- | | |
|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Provider Progress Notes |
| <input type="checkbox"/> Mental Health Evaluation | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> History/Physical Examination | <input type="checkbox"/> Medication Administration Records |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> School Records (IEP's, etc.) |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> All of the above |
| <input type="checkbox"/> Psychological Testing Results | <input type="checkbox"/> Other _____ |

This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. If not earlier revoked, it shall terminate (12) months from the date of authorization without express revocation. I understand that the revocation must be in writing. A copy of this authorization request is to be as valid as the original, and I have received a copy of this authorization.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such a disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

I agree that the above person/organization may FAX the above records

Name of Client (PLEASE PRINT)

Client's Birth Date

Client or Authorized Representative's Signature

Date Signed

Witness

Date Signed