Ψ Susan E. Blandino, Psy.D. Ψ

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Release of Confidential Information

Name:_____ Parent (if under 18):_____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

☐ Treatment Plan ☐ Psychological Evaluation ☐ Telephone Contact

☐ Other_____

Recipient of the information:

☐ Family doctor: Dr._____ phone #: _____ fax #: _____

☐ Psychiatrist: Dr._____ phone #: _____ fax #: _____

☐ School: _____ ☐ Other: _____

This information is being requested for the following purpose(s):

☐ Coordinate treatment

☐ Educational planning

☐ Other _____

This authorization shall remain in effect from the date signed below until

_____(expiration date or until the discontinuation of treatment.)

I understand that:

- **I may inspect or copy the protected health information to be used or disclosed**
- **I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.**
- **Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.**
- **I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)**

☐ **If this box is checked, I understand that you will receive compensation from a third party (insurance company) for the use or disclosure of my information.**

Signature of Patient: _____ Date:_____

Signature of Parent/Guardian:_____ Date:_____