ALISON C. SMITH, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:_____ Date of Birth: _____

I, _____ , give my authorization for Alison C. Smith, Ph.D., to exchange information about me with:

Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

I authorize the individual(s) listed above to disclose the following information (check all that apply):

_____ Complete copy of clinical record (if you **do not** select this option, select specific options below*)*.

_____ *Assessment & Termination Summaries*
_____ *Testing Information*
_____ *Treatment Plan or Summary*
_____ *Continuing Care Plan*
_____ *Psychological/Psychosocial Evaluation(s)*
_____ *Educational/Occupation Info & History*
_____ *Current Treatment Update*
_____ *Progress/Participation in Treatment*

Other: _____

PURPOSE:

The purpose of this disclosure of information is to support treatment/assessment of the client identified above and, when appropriate, to coordinate treatment services with other professionals. If there is a purpose *other than this one*, please specify:

_____

_____

EXPIRATION: This authorization will expire (please check ONLY ONE box)

Note: This authorization will terminate on the earliest option selected.

☐ When I revoke the authorization.

☐ Upon the completion/termination of treatment with the current provider.

☐ Upon the following date, event, or condition _____

ACKNOWLEDGEMENT OF LIMITATIONS & RIGHTS REGARDING AUTHORIZING DISCLOSURE:

- **I understand that the duration of consent shall be consistent with the limitations identified under the "Expiration" portion of this form**. I understand that after that specified expiration condition is met, no more information can be used or released to the person or organization identified above unless a new Authorization for Release of Information form is signed.
- I understand that I can revoke or cancel this Authorization for Release of Information at any time. If I do revoke this Authorization, it will prevent any release of information after the date it is received but cannot change the fact that some information may have been sent or shared prior to the date that the Authorization was revoked.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain and assessment or treatment from Alison C. Smith, Ph.D.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that Alison C. Smith, Ph.D. cannot be held accountable if the individual or organization to whom this disclosure of information has been made chooses to make further disclosures of the information in question.
- I affirm that everything in this form that was not originally clear to me has been explained and I believe that I now understand all of it.

Client Consent to Authorize the Release of Information

I will be provided with a copy of this authorization for my records.

_____
Print Client Name

_____ _____
Signature of Client Date Signed

_____
Print Name of Legal Representative (if applicable)

_____ _____
Signature of Legal Representative (if applicable) Date Signed

If you are signing as a personal representative for the client specified in this document, please describe your authority to act for this individual.

_____

_____

_____

Request for prohibition of redisclosure: This information has been disclosed from records for which confidentiality is protected. I request that you prohibit redisclosure of this information unless further disclosure is expressly permitted by the written authorization from the person to whom it pertains.

A photocopy of this completed release is considered to be as valid as the original document.