Chattahoochee Child Psychology Services, LLC
Consent for Release of Information

Client's Name: _____

Address: _____City: _____ State:_____ Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize Chattahoochee Child Psychology Services, LLC to:

□ (send) □ (receive) the following □ (to) □ (from)

Name: _____

Address: _____City: _____ State:_____ Zip: _____

- ☐ Academic testing results
- ☐ Behavior programs
- ☐ Progress reports
- ☐ Intelligence testing results
- ☐ Medical reports
- ☐ Personality profiles
- ☐ Psychological reports
- ☐ Psychological testing results
- ☐ Service plans
- ☐ Summary reports
- ☐ Vocational testing results
- ☐ Entire record, except progress notes
- ☐ *Psychotherapy Notes
- ☐ Other, specify_____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Coordination of treatment and recommendations
- ☐ Case review
- ☐ Updating files
- ☐ Other (specify) _____

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 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 180 days 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.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____Date: ____/_____/_____

Parent/Legal Guardian Signature: _____Date: ____/_____/_____

Witness:_____Date: ____/_____/_____