Park Ridge Behavioral Healthcare LLC

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Release of Information

☐ **Kenneth Bell, Ph.D.** ☐ **Nicole Rosenberger, LCSW** ☐ **Melissa Jenkins, Ph.D.**

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☐ **Charles, Powell Ph.D.**

When completed and signed by you, this authorizes our office to receive and/or release protected information from your clinical record to the person you designate.

⇒_____ ⇒ _____ ⇒ _____-_____-_____

Patient Name Date of Birth SSN#

I authorize my psychologist or mental health provider and his or her administrative and clinical staff to receive and/or release the following records and information:

☐ Psychotherapy Notes	☐ Right for Verbal Consultation	☐ Psychological Evaluation
☐ Psychiatric Evaluation	☐ Intake Summary	☐ Discharge Summary
☐ Psycho-educational Evaluation	☐_____	☐_____

To: (Name, address, and telephone number of person to whom the information is to be released.)

Name: _____

Address: _____

Telephone: _____

I am requesting my psychologist to receive and/or release this information for the following reasons:

☐ To inform ongoing mental health services.

☐ To inform evaluation services.

☐ _____

This authorization shall remain in effect until the completion of services or until _____.

You have the right to revoke this authorization in writing at any time by sending your notification to this office.

I understand that my provider generally may not condition services upon my signing an authorization unless the services are provided for me for the purpose of creating health information for a third party.

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

⇒ _____ ⇒ _____

Signature of Patient or Guardian Date

⇒ _____ ⇒ _____

Witness Date