Stephanie L. Weber, PsyD

Authorization to Release Information

When completed in its entirety and signed by you, this form authorizes Stephanie L. Weber, PsyD to release protected health information from your clinical record to the person you designate.

I/We _____ do hereby consent to authorize Stephanie L. Weber, PsyD
Client's name

_____ Release information to: _____ Secure information from:

_____Family Doctor _____School _____Other: _____
_____Mental Health Practitioner _____Disability Insurance
_____Lawyer/Attorney _____Individual

Name: _____

Address: _____
City State Zip

Phone: _____ Fax: _____

Information to be released is:
_____For the purpose of treatment planning
_____Other: _____

Please release the following:
_____Treatment Plan _____Termination Summary _____ Psychological Evaluation
_____Clinical Note _____ Progress Reports _____ Recommendations

Other (Please Specify): _____

I understanding that this authorization shall remain in effect as of the date of the signature unless otherwise noted. I also understand that this authorization can be revoked (except to the extent that action has been taken) at any time by dated, with written communication requesting so.

I/We understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and is therefore no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian or Authorized Representative Date

_____ _____
Signature of Witness Date