Best Practice Psychotherapy, LLC
Authorization for Release of Information

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize _____ to: _____ (send)
_____ (receive) the following _____ (to) _____ (from)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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

_____ 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
_____ Others, specify _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ 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 that 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 (some states very, usually 1 year) 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.

Your relationship to client: ____Self ____Parent/legal guardian ____Legal representative
____Other (describe) _____

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/guardians/personal representative (if applicable)

Signature: _____ Date ____/ _____/ ____

Witness (if client is unable to sign)

Signature: _____ Date ____/ _____/ ____