DUTCH FORK PSYCHOLOGICAL SERVICES, LLC

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ ID#_____

This form, when completed and signed by you, authorizes us to share protected information from your clinical record with the person(s) you designate below.

This authorizes: **to exchange information with:**

Dutch Fork Psychological Services, LLC
7313 College Street
Irmo, SC 29063
Phone: (803) 407-7099
Fax: (803) 807-9104

_____
_____
_____

For the purpose of: _____Ongoing care Other: _____

The following information (please initial):

_____Intake/Diagnosis _____Psychiatric Evaluation _____Progress in Education
_____Consultation _____Chemical Abuse Evaluation _____Other:
_____Current Treatment Update _____Treatment Plan _____
_____Demographic Information _____Discharge/Transfer Summary _____
_____Psychological Evaluation _____Arrest Report Documents _____

Specific Authorizations for Release of Information Protected by State/Federal Law
This authorization will last no longer than reasonably necessary to serve the purpose for which it is given, or as limited in paragraph one (1) below, whichever is sooner. This authorization may apply to any/all of the following: Chemical Dependency/Abuse; Mental Health Records; Psychotherapy.

1) I understand that I may submit a written request to Dutch Fork Psychological Services, LLC at any time to revoke this authorization. However, to the extent that action has already been taken in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage, a revocation will not be possible.

   This authorization shall remain in effect until_____or until_____.
   (Date) (Event that relates to the use or disclosure)

2) I understand that future treatment or payment may not be condition upon my signing or not signing this authorization, unless the psychological services are provided to me for the purpose of creating health information for a third party.

3) I hereby release Dutch Fork Psychological Services, LLC from all legal liability that might arise from their release of the information and/or re-disclosure by the recipient of this information. I consider a photocopy of this authorization to be as valid as the original.

Authorization must be signed by the patient or legal guardian of the patient or other authorized representative. If patient is unable to give authorization or physically sign, please state reason:

_____

_____ _____ _____
Signature of Patient or Legal Guardian Print Name Date

_____
Relationship to Patient