RELEASE OF INFORMATION

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I, the undersigned, hereby authorize _____
Provider Name

To release/exchange the following information:

_____ Assessment results
_____ Diagnosis
_____ Recommendations
_____ Compliance with recommendations
_____ Other

TO and FROM:

_____Physician Names: _____
_____ Psychiatrist _____
_____ School/Work _____
_____ Other _____

My authorization for the release of the above information is effective on the date I sign this form and will remain effective for a period of one (1) year from such date.

I understand the I have the right to inspect and copy the information that I have authorized to be used or disclosed as provided for under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulation found at 45 C.F.R. 164.524.

I understand that this authorization is valid until it expires, unless revoked by me.

Signed:_____ Date_____

Witness:_____ Date:_____