LINDEMAN & ASSOCIATES
Psychological Services

Consent for Release or Exchange of Confidential Information_____

I,(Client's Name)_____DOB:_____

Address:_____City:_____ State:_____

Zip Code:_____Home Phone:_____Cell Phone:_____

I Authorize LINDEMAN & ASSOCIATES PSYCHOLOGICAL SERVICES, LLC to exchange with/disclose to the following:

_____

Name of individual or organization to which disclosure is made.

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

The following information:

_____ Academic testing results
_____ Behavior programs
_____ Progress Notes
_____ Intelligence testing results
_____ Medical reports
_____ Personality profiles
_____ *Psychotherapy notes
_____ Psychological reports
_____ Psychological testing results
_____ Service plans
_____ Summary reports
_____ Vocational testing results
_____ Entire record, except progress Notes
_____Other_____

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
_____ Other_____
_____ Case review
_____ Updating files
_____ To comply with court order

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 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 one 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.

LINDEMAN & ASSOCIATES Psychological Services

Your relationship to client: ____Self____Parent/Legal Guardian____Personal Representative _____Other

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/Guardian/Personal Representative (if applicable)
Signature: _____Date:____/____/_____

Witness (if client is unable to sign)
Signature: _____ Date:____/____/_____