CENTRAL PSYCHOLOGICAL SERVICES, LLC

mind·body·spirit

Consent for Release of Information

Client's Name:_____ DOB_____

Address: _____

I, _____, authorize_____ of Central Psychological Services, LLC to **send** the following information to:

Recipient's Name: _____

Address: _____

Recipient's Phone: _____

Information to Be Sent

- ☐ Clinical intake assessment
- ☐ Academic testing results
- ☐ Intelligence testing results
- ☐ Psychological test scores
- ☐ Psychological reports
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Background information from other providers
- ☐ Raw psychological test data and materials
- ☐ Entire file except psychotherapy notes
- ☐ Verbal communications and exchanges
- ☐ *Psychotherapy notes
- ☐ Invoice for payment
- ☐ Other _____

*** A separate authorization, as defined by HIPAA, is required for psychotherapy notes**

The above information will be used for the following purposes:

- ☐ Conducting psychological assessment
- ☐ Planning appropriate treatment
- ☐ Coordinating appropriate treatment with the sender or another party
- ☐ Determining eligibility for benefits or program
- ☐ In compliance with court order or legal requests
- ☐ At the request of the client
- ☐ Other_____

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, especially Indiana Code 16-39. I further understand the information disclosed to the recipient may not be protected under these guidelines if he or she is not a health care provider covered by state or federal rules.

I understand that the clinician will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. Information disclosed pursuant to the authorization is subject to redisclosure by the recipient and would no longer be protected by this authorization.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, except to the extent to the information that has already been released, 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 with exception to the extent that the information has already been released.

Client's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

Parent or Guardian Signature (if applicable): _____ Date: _____

Parent or Guardian Printed Name: _____ Relationship to client: _____

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