



AUTHORIZATION FOR RELEASE OF CLINICAL INFORMATION

PATIENT NAME		Date of Birth Phone		
Address		Phone		
I authorize Hanna Psychological S health record, indicated below, to		use or disclose information from m	y mental	
Name:		Phone		
Address:		FAX		
Information to be released Initial Assessment Treatment Plan Summary of Treatment Testing/Formal Observation		☐ Progress Notes ☐ Discharge/Transition Plan ☐ Other		
Purpose of Disclosure:				
expire 1 year from the date as valid as the original. Val. 2. I understand that I may rev. Psychological Services, PC authorization will cease to has already been taken in results. I understand that my refusation obtain present or future tree of the information is necess. 4. I understand that I can require	of signature. lid until	Authorization will not jeopardize when the control of the control	g Hanna I that this extent action e my right to re disclosure	
Notice to Recipient: Under of the information provided with		dentiality rules, you may not red authorization to do so.	isclose any	
By signing below, I acknowledge	ge that I have	read and understand this Author	rization.	
		OR		
Signature of Patient	Date	Parent/Legal Guardian	Date	
Signature of Clinician	 Date			