HOME PSYCH SERVICES, P.C.

Quality Behavioral Healthcare
in the Comfort of Your Home™

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Full Name: _____

Patient of Provider: Home Psych Services

Date of Birth: _____SSN: _____

I hereby authorize the release of information or the request of records.

Release to_____ / Obtain From: _____

Address _____ / Address: _____

Information to be Released/obtained

- ☐ Psychological evaluations, reports, or Treatment Notes and Summaries
- ☐ Admission and Discharge Records
- ☐ Billing Records
- ☐ Academic or Educational Records
- ☐ Teacher Observation Reports
- ☐ Results of Psycho-Educational Testing
- ☐ Medical Records

Purpose of this authorization:

- ☐ Facilitate evaluation or treatment
- ☐ Provide information for insurance purposes
- ☐ Provide information for a legal matter

It is understood that the duration of this consent will not be longer than would be necessary and reasonable to carry out the purposes for which is given. This consent is subject to revocation in writing at any time by me or my legal guardian. However, actions already taken as specifically allowed by this form cannot be cancelled by ending your consent. The terms of this consent form will end one (1) year from the signed date before with no further action on my part.

I acknowledge that I have read and fully understand this authorization as it applies to me. By my signature below, I authorize execution of terms of this document.

_____ _____

Signature of Client/Legal Guardian Today's Date

_____

Printed Name

_____ _____

Witness's Signature Date Witnessed

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