Powers Ferry Psychological Associates, LLC

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I hereby authorize _____ (Therapist's name)

to: ( ) release ( ) receive ( ) exchange

information concerning _____ (Name of Patient, DOB)

( ) to ( ) from ( ) with _____ .

I understand that such disclosure will be made for the following purposes:

( ) Treatment Progress
( ) Psychological Evaluation
( ) Medical Treatment
( ) Academic Placement
( ) Psychiatric Evaluation
( ) Social History
( ) Treatment Summary
( ) Diagnosis
( ) Child Custody / Visitation
( ) Competency to stand trial
( ) Emergency Concern
( ) Other _____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and, if not earlier revoked, it shall terminate on _____ without revocation.

I understand that disclosures may not be subject to confidentiality if the therapist becomes aware of any suicidal or homicidal thoughts or plans, or in the event that the therapist becomes aware of any form of abuse or neglect.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

_____ I authorize this information to be sent to the party indicated above by one or more of the following
(Initial) means, and understand the limits of confidentiality which doing so creates.

Please check all that apply: ( ) Faxed ( ) Texted ( ) E-mailed ( ) By Phone

_____ _____
Signature of Patient, Parent, or Legal Guardian Date