Smith Psychological Services

Phone Number: 307-632-7771 Fax Number: 307-632-9697 Email: admin@smithpsychological.com

Authorization For the Release of Confidential Information

On behalf of, _____, _____, _____,
(Name of Client) (Date of Birth) (last 4 of SSN)

I authorize **Smith Psychological Services** to release/receive information to/from:

Name:_____

Address:_____

Phone Number: _____ Fax Number:_____

Purpose/Reason for disclosure:
( ) Psychological Evaluation/Continuing of Care
( ) Billing or Insurance Purposes
( ) Legal Proceedings
( ) Other - Please list _____

Range of Dates: ( ) Any/all previous dates at your facility or ( ) _____ to _____

Type of Information Requested:

( ) Progress Notes	( ) Grades
( ) Clinic Notes	( ) Attendance
( ) Admission/Discharge Summary	( ) Behavioral Notes and Records
( ) History & Physical	( ) 504
( ) Nurse Notes	( ) Confidential Special Education File (i.e., IEP, triannual eval)
( ) All Hospital Records	( ) Psychoeducational Report
( ) Medication List	( ) Other _____

I understand that my child's/wards records are protected under the Federal and Specific State confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may, in writing, revoke this consent at any time, except to the extent that action has been taken in reliance on it (such as the provision of treatment upon consent to disclose to third-party payers) or after the occurrence of a specified ascertainable event (such as release from probation or parole). In any event, this consent expires automatically as described below. I acknowledge that the information released was fully explained to me and this consent is given of my own free will.

This consent expires 17 /20 /____ or no later than one year from the date of signature.

_____ _____
Client/Parent or Guardian Signature Date