Authorization for Release of Confidential Information

Name:_____DOB:_____

Address:_____

I, _____, authorize D. Russell Bishop, Psy.D., Clinical Psychologist, 4700 N. Cloverdale Road, Boise, Idaho 83713, (208) 999-0785, to

☐ **disclose to or** ☐ **to request from: _____**

The following information:

☐ All Health Records

Or, mark one or more of the following:

☐ Comprehensive Medical Assessment
☐ Psychological Evaluation
☐ Medical Social Assessments
☐ Developmental Therapy Progress Charts/Reports
☐ Developmental Therapy Evaluation
☐ Psychosocial Rehabilitation Reports
☐ Vocational Reports
☐ Person Centered Plans
☐ Vocational Progress Information
☐ Other (Specify) _____

The purpose or need for such disclosure:

☐ Diagnosis and Treatment Plan ☐ Determining eligibility for services ☐ Discharge Plan
☐ Other (Specify) _____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. You have my additional authorization to release information that may pertain to mental health care or treatment and/or to alcohol, drug, or substance abuse. I understand that the information disclosed pursuant to this Authorization may potentially be redisclosed by the recipient and may no longer be protected by state and federal privacy laws.

If an agency (e.g. probation, parole, etc.) has taken an action on my behalf which relies upon this release, I understand that I will abide by the stipulations of that action. I also understand that I may revoke this consent in writing at any time, except to the extent that it has been relied upon by the Practice, by contacting the Practice at the address above. This consent automatically expires 6 months after my termination from the Practice. I release the Practice from any or all responsibility and liability concerning the release of information I have consented to above. I agree that a copy of this release may serve as the original.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ Yes ☐ No _____ Initials

Signature:_____ **Date: _____**

Parent or Legal Guardian:_____ **Date: _____**

Witness: _____ **Date: _____**

This authorization will expire: _____ (insert date or event)

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***