

MENDEL PSYCHOLOGICAL ASSOCIATES

Child, adolescent, adult and family psychological services

3727 Benson Dr
Raleigh, NC 27609

www.DrMendel.com
tel: 919-876-1313, fax: 919-882-1567

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:

Date of Birth

Address:

Phone:

Parent or Legal Guardian:

This form, when completed and signed by you, authorizes Mendel Psychological Associates to share protected information from yours of your child's clinical record by:

- Releasing of information to
- Exchanging information with
- Requesting information from

Name of person or Agency

Address

Phone, Fax number

This information will include:

- Testing
- Treatment Plan
- Therapy Notes
- All of the Above
- Other (Specify):

I am requesting the exchange of information for the following reason:

- At my request
- Other (Specify):

This authorization shall remain in effect in effect for: 180 days, or ending ___/ ___/ ____, or till the end of the treatment

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date:

Signature of Parent or Legal Guardian