REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

This request hereby authorizes **PAUL BECKER, PH.D., DAVID UDELF, PSY.D., PATRICIA MASTERSON, PH.D**. to obtain and/or disclose protected information from the clinical record of:

_____**Myself** _____
Your Full Name

_____**My child,** _____
Child's Full Name **Relation to Child**

CHECK ONE OF THE FOLLOWING OPTIONS:

_____ I grant my permission to release all pertinent medical, psychological, or legal information pertaining to my child or myself.

_____ I grant my permission to release pertinent medical, psychological, or legal information pertaining to my child or myself with the following restrictions:

_____

_____

TO AND/OR FROM THE FOLLOWING PROFESSIONAL, INDIVIDUAL, OR ORGANIZATION:

_____
NAME **TITLE/RELATION TO CLIENT**

_____
ORGANIZATION

_____
ADDRESS

_____
PHONE NUMBER **FAX NUMBER**

I voluntarily authorize and request to release/obtain information from my records and fully understand the nature of the records and information to be released.

I understand and acknowledge that this authorization extends to all or any part of the records designated above which may include documentation of treatment for physical and emotional difficulties, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. I expressly consent to the release of the information designated above.

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already occurred. ***Such revocation must be in written form and dated***. This consent will expire automatically when the treatment in concluded unless otherwise stated in writing.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and, therefore, no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____
SIGNATURE OF CLIENT OR PARENT/GUARDIAN **DATE**

_____ _____
SIGNATURE OF WITNESS **DATE**