

## REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

This request authorizes **PAUL BECKER, PH.D., DAVID UDEL, PSY.D., PATRICIA MASTERSON, PH.D.,** and **DANA BLOCKER, LISW-S** to obtain and/or disclose protected information from the clinical record of:

\_\_\_\_\_ Myself \_\_\_\_\_  
Your Full Name  
\_\_\_\_\_ My Child \_\_\_\_\_  
Child's Full Name

### 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  
\_\_\_\_\_  
Organization  
\_\_\_\_\_  
Street Address City State Zip  
\_\_\_\_\_  
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 many 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 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 is 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)*.

\_\_\_\_\_  
Name of Client or Parent Guardian (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature