PSYCHOLOGICAL ASSESSMENT CENTER, LLC

Client Authorization to Obtain/Release Information

Client Name _____ Date of Birth _____

I authorize my psychologist, and/or their administrative and clinical staff to obtain/release the following information (check all applicable boxes):

- ☐ Release psychological treatment records
- ☐ Release psychological testing records
- ☐ Obtain medical/psychiatric treatment records
- ☐ Obtain medical/psychiatric testing records
- ☐ Obtain psychological testing/treatment records
- ☐ Obtain educational testing/assessment records
- ☐ Other: _____

This information should be obtained from/released to:

Name _____

Address _____

_____

I am requesting Psychological Assessment Center to obtain/release this information for:

- ☐ Purposes of psychological assessment and/or treatment
- ☐ At the request of the individual
- ☐ Other: _____

This authorization shall remain in effect until_____ (date)
or until _____(event)

By signing below, I agree to the following conditions:

- I have the right to revoke this authorization at any time by sending a written request to Psychological Assessment Center. However, my revocation will not be effective to the extent that Psychological Assessment Center may have already taken action in reliance on the authorization.
- Psychological Assessment Center 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.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Client or Authorized Agent of Client Care Date

_____

Relationship of Above to Client (e.g., self, parent, legal guardian)

3320 SKYWAY DRIVE, SUITE 801, OPELIKA, AL 36801
334-742-9102 (PHONE); 334-742-9103 (FAX)