Yara A. Perez, LCPC, CST
HOLISTIC PSYCHOTHERAPY

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Identifying Information About Me/Patient:

PATIENT NAME: _____ Birthdate: _____

Street Address: _____

City/State/Zip: _____ Phone: _____

PARENT/GUARDIAN (if applicable) _____

Street Address: _____

City/State/Zip: _____ Phone: _____

Release or Obtain Information to/from:

PERSON or FACILITY: _____

Street Address: _____

City/State/Zip: _____ Phone: _____

I _____ **hereby authorize Yara Perez LCPC, CST to,**
(name)

- ☐ Obtain written medical/clinical records and information from:
- ☐ Disclose written medical/clinical records and information from:
- ☐ Obtain and disclose medical/clinical records and information in verbal discussions with:

the source named above, the records listed below marked by an X in the boxes below. (The items not to be released have a line drawn through them.) Page numbers are indicated where appropriate. Written dates (other than those regarding inpatient admission/outpatient treatment) indicate when those records were mailed to the requester.

☐ **All information,** including history, dates, course and outcome of treatment, all items listed below, and any other significant information.

OR only the following information listed below marked by an "X"

☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:

Date(s) of inpatient admission: _____

Date(s) of outpatient treatment: _____

Other identifying information about the service(s) rendered: _____

- ☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
- ☐ Psychiatric evaluations, reports, or treatment notes and summaries.
- ☐ Treatment plans, recovery plans, aftercare plans.
- ☐ Admission and discharge summaries.
- ☐ Social histories, assessments with diagnoses, prognosis recommendations, and all similar documents.
- ☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.
- ☐ A letter containing dates of treatment(s) and a summary of progress.

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HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

☐ Do not release HIV-related information
☐ Do not release drug and alcohol information.
☐ Other:

I authorize the source named above to speak by telephone with the therapist identified in part N, below, about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information dis-closed may be used in connection with my/the patient's treatment.

This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursu-ant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the

pa-tient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 90 days from the date I signed it.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of client (or parent/guardian/representative)	*Printed Name*	*Date*
Signature of partner/spouse	*Printed Name*	*Date*

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I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional	*Printed Name*	*Date*

☐ Copy for patient or parent/guardian
☐ Copy for source of records
☐ Copy for recipient of records

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