AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

LOGICAL
BEHAVIORAL HEALTH

I, _____
D.O.B.: _____ SS#: _____
hereby authorize the □Release □Exchange □Request
Of the following Protected Health Information (PHI):

PHI From:	Disclose PHI To:
_____	_____
_____	_____
_____	_____
_____	_____

PHI To Be Disclosed:

_____
_____

Purpose of Disclosure of PHI:

_____
_____
_____

Unless otherwise revoked in writing, this authorization expires:

_____
_____

I understand that my records are protected under the laws and regulations relating to the practice of psychology governed by the Board of Psychology (Sections 1012, 1013, & 1014). I further understand that my records cannot be disclosed without my written consent unless otherwise provided for in these regulations. I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire as stated above. By signing below, I acknowledge that I release the above named organization/individual(s) from all legal liabilities that may arise from this situation.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian's Signature Date

_____ _____
Therapist's Signature Date

Confidentiality of Records

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making further disclosure of these records without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This authorization for release of information may be considered as an original in instances of fax transmittal.