Authorization to Release and/or Receive Healthcare Information

Name of Client: _____ Date of Birth: _____

Address: _____

I request and authorize Jessica Grossnicklaus, PsyD, LLC to (check one):

____ Obtain information from
____ Send information to
____ Obtain AND send information to/from

_____ _____
Name of Provider/Agency/Person Address

_____ _____
Phone Fax

Information requested to be release (check all that apply):

____ Entire Record ____ Diagnostic Evaluation ____ Treatment Plan
____ Progress Notes ____ Psychological Testing ____ Treatment Summary
____ Medical History/Medications ____ Discharge Summary ____ Other_____

I understand this authorization will expire 1 year from the date signed or until _____.
Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care, or further medical treatment. I have reviewed this authorization form and confirm it reflects my wishes to release/receive protected healthcare information. I understand what information will be given, its purpose, and who will receive the information. I understand I have a right to receive a copy of this authorization. I understand I have a right to refuse to sign this authorization or to revoke my authorization at any time by providing written notice. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Jessica Grossnicklaus, PsyD, LLC from any liability resulting from this disclosure. A photocopy or fax of this document shall have the same effect as the original.

Signature of Client/Guardian **Date**

Signature of Witness **Date**

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