AUTHORIZATION FOR RELEASE OF INFORMATION

Village Presbyterian Church
Dave Ehman, Ph.D.
Licensed Psychologist

TO: _____ **CLIENT NAME**: _____

ADDRESS: _____

PHONE: _____**FAX**_____ **DATE OF BIRTH**: _____

I, the undersigned, do hereby authorize the above named person, firm, physician, psychologist, counselor/therapist, attorney, clinic, school, hospital, or any authorized employee of the same

☐ _____**TO FURNISH TO DAVE EHMAN, Ph.D.**

☐ _____**TO RECEIVE FROM DAVE EHMAN, Ph.D.**

full and accurate information regarding any medical, psychological, academic or social history, including any special reports and other pertinent data as specified below regarding the above client.

I hereby release Village Presbyterian Church and Dr. Dave Ehman from any liability for information pursuant to this authorization. I understand that my records are protected by state and federal law, and cannot be disclosed without my written consent unless otherwise provided by law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall remain in effect until: _____. A photocopy of this document with the signatures hereon shall be considered as valid as the original.

I understand that my psychotherapist generally 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.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

INFORMATION REQUESTED:

☐ _____REPORT OF PSYCHOLOGICAL TESTING

☐ _____CLINICAL RECORD

_____MEDICAL RECORDS

☐ _____OTHER _____

PURPOSE OF DISCLOSURE: _____

_____

Client Signature Date

_____

Witness Date