



BRAIN BUILDERS

NEURO THERAPY

Eileen Roberts PhD PSY21296

Authorization to Obtain/Release Confidential Information

Client Name _____ Date of Birth _____

I hereby authorize Eileen Roberts, M.A., Ph.D. and/or her staff to obtain/release information regarding medical, psychological, psychiatric, drug/alcohol treatment or other information indicated below for the purpose of treatment planning to/from:

Name: _____

Address: _____

Phone: _____

I am requesting my psychologist to release /obtain this information for the following reason:

Such disclosure shall be limited to the information indicated below:

_____ Clinical Diagnosis	_____ Psychological Test Results
_____ Summary of Treatment	_____ Financial Record
_____ Insurance Summary	_____ Substance Abuse History
_____ Psychosocial History	_____ Prognosis
_____ Laboratory/Medical Records	_____ Other _____
_____ Complete Medical Records (all of the above and any other materials in my file)	

This authorization shall remain in effect until:

_____ The end of treatment _____ One year from the date of signature
_____ (Specified date)

I have been informed of my legal rights regarding the release of confidential information and hereby authorize the release of such information as described above. I realize I may revoke this authorization, in writing, at any time by sending such written notification to Dr. Robert's office address. However, this revocation will be acted on at the time received by Dr. Roberts and she will not be held liable for actions taken prior to the time of her receipt of said revocation. I also understand that If I am seeking insurance coverage, the insurer has a legal right to require information from my treatment records. I understand that information disclosed by Dr. Roberts to another party may be subject to redisclosure by said recipient and that Dr. Roberts can not be held liable for such redisclosure. I have received and read information regarding HIPAA and its effects on my private health information.

Signature of Client Date Witness

Signature of Client's representative

Relationship to client)