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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, authorize Hillary Wishnick, Ph.D to release the following information from my (or give relationship _____) medical/clinical or financial record. This authorization includes release of information concerning drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and/or HIV status and related conditions and/or AIDS or AIDS-related conditions. Review of the records is also authorized.

Patient Information (Please Print)

Name: _____ Date of Birth: _____ SS#_____

The following information may be released or reviewed:
θ Academic Records θ Assessment Registration θ Case Summary θ Closing Summary θ Diagnosis θ Doctor Orders θ Psychological Tests θTreatment Plan θ Lab/Medical Results θPsychological/Consultation Reports
θ Other _____ θ**All Information Listed Above**

The above information is to be forwarded either by mail, fax, electronic transmission, picked up or reviewed to:

Name of Person: _____
Agency/Organization: _____
Street Address: _____
City, State, Zip Code: _____

The above information is requested to be released for the following purposes only: _____
_____.

PROHIBITION OF REDISCLOSURE: This information is being disclosed from records where confidentiality is protected by Federal Law including CFR42. Federal regulations prohibit you from making further disclosure of this information except with specific written consent or the person to whom it pertains. A general authorization for the release of clinical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus is no longer protected by the state/federal privacy regulations, including the HIPAA Privacy Rule.

The statement must be signed and dated, and may be revoked at any time to the extent action has been taken prior to revocation of this authorization. In order to revoke the authorization the individual/parent/legal guardian who authorized the initial release must do so in writing. **This consent will expire ninety (90) days after the date below, or sooner by my choice, in which case this consent will expire on _____.**

I understand that a standardized fee has been established for copies of medical/clinical records. Please inquire regarding these fees prior to requesting copies. A faxed or xeroxed copy of this release may replace the original copy.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

_____ _____
Signature of Client or Parent if Minor **Date Signed**

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