The Wake • Kendall Group PLLC
Psychotherapy & Assessment

AUTHORIZATION FORM

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the people you designate and/or obtain information from them.

I authorize: _____ (Psychologist/ Educational Consultant/Therapist) to release and /or obtain the following information regarding: (client):_____

Reason for release of information:
a) Facilitate treatment planning
b) Educational planning
c) Other _____

This information should only be released to and/or obtained from the following people:

Name	Address/ Phone Number

I understand the following:

- This authorization shall remain in effect for up to 60 days from the date signed or until the following date (if earlier): _____
- I have the right to revoke this information in writing at any time; however the revocation will not be effective to the extent that that this authorization already has been exercised. There are restrictions on revocation when authorization was given as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I have the right to inspect the disclosed mental health information at any time.
- My psychologist may not condition psychological services upon my signing an authorization.
- The information used or disclosed may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

_____ _____
Signature of Client or Representative Date