Barbara Fordyce & Associates, LLC
4319 Hills & Dales Rd NW, Canton, OH 44708, (330) 492-2006

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This form when completed and signed by you authorizes the release of protected information from your clinical record to the designated person.

I (Client Name) _____ authorize _____to

request and/or release the information designated below to:

Facility / Individual: _____

Address: _____

Phone No. _____ Fax No. _____

I hereby authorize Barbara Fordyce & Associates, LLC to REQUEST and/or RELEASE the following information to/for the above listed facility/individual to aid in treatment.

	Request	Release
Reasons for Referral	_____	_____
Medical History and Physical Exam	_____	_____
Medication Record/Laboratory Reports	_____	_____
Psychoeducational Evaluation	_____	_____
School Records (Teacher Observations, Grades, etc.)	_____	_____
Psychological Testing	_____	_____
Evaluation of Emotional Status	_____	_____
Treatment Summary	_____	_____
Discharge Summary/Evaluations	_____	_____
Recommendations/Impressions	_____	_____
Other (please specify): _____	_____	_____

Release Format:Verbal _____ Written _____ Fax _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice to Barbara Fordyce & Associates, LLC. This release will remain in effect until revoked by the undersigned. I understand that any information released prior to the revocation cannot be retrieved by Barbara Fordyce & Associates, LLC and and Barbara Fordyce & Associates, LLC will not be held responsible for such. I hereby release Barbara Fordyce & Associates, LLC from all legal responsibilities or liability that may arise from this act. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Patient signature: _____ Date: _____

Witness Signature: _____ Date: _____