Patient Number: _____

Consent to Release Information

Effective September 1, 2011

This form authorizes Integritas Psychological Services, Inc. to release your confidential and protected health information.

Patient Name: _____DOB: _____

Address: _____

_____

Record Authorization

I, _____, authorize Integritas Psychological Services,

Inc. to share the following with _____.

___ Academic testing results
___ Behavior programs
___ Progress reports
___ Intelligence testing results
___ Personality profiles
___ Psychological reports
___ Psychological testing results
___ Payment plans
___ Summary reports
___ Vocational testing results
___ Entire record
___ Psychotherapy notes*
___ Other, please specify:
_____

*a separate authorization, as defined by HIPAA, is required for psychotherapy notes

I understand this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164), plus applicable state laws.

I understand this authorization is voluntary and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I further understand I have a right to refuse authorization and I have a right to receive a copy of this consent for my records.

patient initials _____

Patient name (please print): _____

Signature: _____ Date: _____

Signed by: __ patient __ parent/guardian __ personal representative

Witness signature: _____