Child and Adolescent Psychology Professionals
Gina De Simone Psy.D., PLLC
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Authorization for Release or Disclose of Records/Information

Client's name: _____ Date of Birth: _____

Address: _____

I hereby authorize the release/request of copies and/or discussion of the specified information included in my mental health and/or assessment* records obtained in the course of psychotherapy treatment including but not limited to HIPPA Protected Health Information (PHI). Psychotherapy notes as defined by HIPPA cannot be released without your written consent and are maintained separately from the mental health record. I understand that a records request may take up to 10 business days to process. Furthermore, I understand that if my request lacks any of the information requested below, the processing time may be delayed.

Specific information to be released:

_____
_____
_____

Specific purpose of release (please specify if this is for verbal communication only)

_____
_____
_____

Release information <u>from</u> Dr. De Simone to:

Name: _____

Address: _____

Phone/fax number: _____

Release information <u>to</u> Dr. De Simone from:

Name: _____

Address: _____

Phone/fax number: _____

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Dr. De Simone has already used or disclosed the information in reliance to this authorization.

_____ _____

Signature of legal guardian Date Signature of legal guardian Date

*Assessment protocol is confidential and copywrited material. Assessment data can only be released to professionals/clinicians who are trained to interpret such information and will only be released to such an individual with your written consent. DES/May 2012