Authorization for Use or Disclosure of Protected Health Information

Client's name ____ DOB___________________________________

I, ________________________________, hereby give my permission to Momentum Psychological and Assessment Services to receive and exchange verbal and written clinical/medical/forensic or other information with:

____ ____

Individual/Agency Title/Relationship

____ ____

Address Phone/Fax Number

Purpose of Release (Must be completed and **initialed** by the client/parent/guardian):

__ Aid/assistance by the above named agency
__ Continued care by the receiving party
__ Assessment/treatment
__ Coordination of treatment with another party
__ Claims settlement with Insurance company
__ Legal proceedings or advice/court order
__ Other: ____

Information to be released (Must be **initialed**):

__ Assessment/Evaluation
__ Discharge Summary
__ Progress Notes
__ Consultation
__ Client Plan/Treatment Plan
__ Educational Tests/Reports
__ Medication Records
__ Other: ______________
__ Psychological Testing
__ History & Physical Exam
__ Physician's Orders
__ ALL INFORMATION*

I further release my attending physician/psychiatrist, counselor, clinic and/or employee thereof from any liability arising from the Release of Information to the person(s)/agency designated above. I consent to the authorized release of my records by facsimile (fax) or email, which will be as valid as an original.

This Authorization for the Release of Information is to remain valid until permission is withdrawn in writing or for a period of one (1) year.

____ ____

Client, Parent or Legal Guardian's Signature Date Signed

____ ____

Minor Child Date of Birth

____ ____

Minor Child Date of Birth