Anne Wright, PhD, PLLC
Child & Adolescent Assessment

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Authorization for Disclosure of Healthcare Information

Client Name: _____

Birth date: ____/____/_____ SS #: ____-____-_____

Previous Name(s): _____

Address: _____

.....

Anne Wright, PhD, is authorized to ☐ disclose and/or ☐ receive information from:

Name of Person/Agency: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

For purposes of: ☐ evaluation ☐ treatment ☐ coordination of care ☐ other: _____

.....

I authorize the release of:

☐ General Mental Health Record

☐ Information related to chemical dependency/substance abuse

☐ Psychotherapy Notes (the private content of your conversations with your therapist)

☐ Information related to HIV/AIDS and/or sexually transmitted diseases

☐ Other: _____

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I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 12 months after the last dated signature.

Signature of Client: _____ Date: _____

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, the parent/guardian is encouraged to sign, but it is not required. I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

_____

Parent/Guardian or Authorized representative—Print Name

_____ Date: _____

Signature of Parent/Guardian or Authorized representative

_____ Date: _____

Signature of Witness