

## PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize and request Dr	of Woodview Psychology Group (WPG) to release and/or obtain the
information described below pertaining to the tre	atment ofwhose date of birth is
to/from:	
Person/Organization:	
Address:	
Telephone:	Fax:
I authorize WPG to <i>exchange with rel</i> information:	case to obtain from the party listed above the following type of
☐ Full Record	Appointment Records
Psychological Evaluation/Report	School Records
☐ Progress Notes	Billing/Financial Records
☐ Treatment Plan	☐ Drug/Alcohol Records
Other:	
mechanisms. WPG and the above designated per information released.  The purpose of disclosure:	son <b>may may not</b> discuss by telephone the content of the
☐ Coordination of Care/Treatment Planning	Transfer Care
Academic Planning	Legal Proceedings
Other:	
federal privacy regulations, the information he/sl recipient may re-disclose the information. Howe information under the Federal Substance Abuse C	s information is <i>not</i> a health care provider or health plan covered by the receives will no longer be protected by these regulations, and the ver, the recipient may be prohibited from disclosing substance abuse onfidentiality Requirements. I hereby release all parties stated herewith is information. I agree that a photocopy of this release shall be as valid as
I understand that this authorization is voluntary. benefits on whether I sign this authorization.	WPG will not condition treatment, payment, enrollment or eligibility for
authorization in writing at any time by sending a	ate I signed the authorization. I understand that I may revoke this written revocation of authorization to: Woodview Psychology Group, 70 inderstand that my revocation is not effective to the extent that action has
Signature of Client or Personal Representative	 Date