

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I \_\_\_\_\_, born on \_\_\_\_\_, hereby authorize:

Psychology Associates of Chester County, Inc.  
273 W. Uwchlan Avenue  
Downingtown, PA 19335  
(610) 873-4748

To release and/or obtain, the following information in  my records  my child's records:

- Mental health and medical history, including diagnosis
- Records of outpatient treatment
- All diagnostic, psychological assessment
- Academic records including grades and standardized testing scores
- Other: \_\_\_\_\_

This information is to be  released to  obtained from:

\_\_\_\_\_

This information is to be released for the following purpose(s):

- Treatment planning & coordination of care
- At the request of the individual, parent or authorized agent
- Forensic Evaluation – I understand that my authorization to release the results of the evaluation may present favorable or unfavorable implications related to the assessment findings and/or recommendations. I have been informed of the risks pertinent to participation in a forensic evaluation during my initial appointment. {Initials: \_\_\_\_\_}
- Other: \_\_\_\_\_

I understand that I have the right to revoke consent to future disclosure in writing at any time, however this revocation will not be effective to the extent that I have already taken action in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment generally may not be conditioned on signing a release of information, unless the services are provided to me for the purpose of providing information to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA privacy rule. I acknowledge that I have had the opportunity to discuss and ask questions about issues concerning privacy and confidentiality and this consent.

This is authorization will remain in effect until \_\_\_\_\_ unless otherwise revoked in writing at a future point in time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date