Be the author of your story...

Emergent Pathways Psychotherapy

Dr. Kaden J. Stanley, Psy.D

Licensed Clinical Psychologist TX #36976
3303 Louisiana St., Suite 260, Houston, TX 77006
ks@emergepsych.com

Request/Authorization to Release Confidential Records and Information

A. Person or facility:

_____

_____

Address:

_____

_____

Phone:

_____

B. Identifying information about me/the patient:

Name:

_____

Address:

_____

_____

Phone: _____

Birthdate: _____

Parent/guardian (if applicable):

_____

Address and phone of parent/guardian:

_____

_____

C. I hereby authorize the source named above to send, as promptly as possible, the records listed below marked by an **X** in the boxes below:

❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse ❑ Psychological evaluation(s) or testing records, and ❑ Psychiatric evaluations, reports, or treatment behavioral observations or checklists completed by notes and summaries ❑ Treatment plans, recovery plans, aftercare plans ❑ Admission and discharge summaries ❑ Social histories, assessments with diagnoses, prognoses ❑ Workshop reports and other vocational evaluations and ❑ Billing records ❑ Academic or educational records ❑ Report of teachers' observations ❑ Achievement and other test results ❑ A letter containing dates of treatment(s) and a summary of progress. HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

❑ Do not release HIV-related information

❑ Do not release drug and alcohol information.

Other:

_____

_____

_____

___

D. Select only one:

❑ Please forward the records to the address in the letterhead at the top of this form.

❑ Please forward the records to the address written below:

_____

_____

E. I authorize the source named above to speak by telephone with Dr. Stanley about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

F. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

G. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance

with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191. H. In consideration of this consent, I hereby release the source of the records from any and all liability arising there from.

H. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/ authorization, it will automatically expire in 90 days from the date I signed it.

I. Signatures:

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____

Signature of client

_____

Date

_____

Signature of parent/guardian/representative

_____

Date

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Kaden J. Stanley, Psy.D.