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**CONSENT FOR RELEASE OF PRIVATE INFORMATION**

HIPPA COMPLIANT: "Authorization to Use and Disclose Protected Health Information"

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ SSN: \_\_\_\_\_

**I / WE HEREBY AUTHORIZE THE DISCLOSURE OF THE FOLLOWING INFORMATION FROM MY / OUR RECORDS IN WRITING AND/OR BY TELEPHONE:** (indicate items:)

- \_\_\_\_\_ Results of Evaluation interviews.
- \_\_\_\_\_ Results of Psychological Testing.
- \_\_\_\_\_ Narrative Case History, Diagnosis, Treatment Plan, Progress Notes.
- \_\_\_\_\_ Ongoing Reports on Treatment Progress.
- \_\_\_\_\_ Termination Record and Recommendations for Further Treatment.
- \_\_\_\_\_ Telephone consultation.
- \_\_\_\_\_ Other: (specify:) \_\_\_\_\_
- \_\_\_\_\_

**THIS RELEASE IS FOR THE PURPOSE OF:** \_\_\_\_\_

**INFORMATION will be SENT / EXCHANGED between MICHAEL E. METZ, Ph.D and:**

\_\_\_\_\_  
(person with whom information is to be exchanged) Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
(address where information is to be sent)

\_\_\_\_\_  
(address where information is to be sent)

(Continued on next page)

**HIPPA COMPLIANT: "Authorization to Use and Disclose Protected Health Information"**

- 1 I understand and agree that this Authorization will be valid and in effect for one year or until \_\_\_\_\_ [Enter a date or event upon which this Authorization expires.] I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- 2 I understand that I can revoke or cancel this authorization at any time by sending a letter to Michael E. Metz, Ph.D. who is to supply this information. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.
- 3 I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.
- 4 I understand that I may inspect and have a copy the health information described in this authorization.
- 5 I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
- 6 I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- 7 **I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.**
- 8 **I acknowledge that I received a copy of this completed form**

**Authorization for release of information:**

▶ \_\_\_\_\_  
o (Client signature) (Date)

▶ \_\_\_\_\_  
o (Client signature) (Date)

**The original will remain with the clinical file. A copy of this form can be considered as valid as the original. This release expires one year from date of signature and may be revoked by the signer at any time prior to that date.**

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

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Michael E. Metz, Ph.D.

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Date

(Rev. 4-14-03)