AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Dawn Huebner, Ph.D.

This form, when signed by you, authorizes me to release Protected Information from your child's Clinical Record to the person you designate.

Child's Name ___________________________________ DOB _____________________________________

I hereby authorize Dawn Huebner, Ph.D. to:

_____Release To _____Obtain From

Name ____

Address ____

____

Telephone ______________________________________ FAX _____________________________________

I authorize release of the following information:

_____clinical notes _____school records _____psych. evaluations

_____treatment plan _____other (specify)

This release is for:

_____Facilitating evaluation, treatment planning and/or coordination of care

_____A legal matter (specify)

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken on my original authorization to release information.

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 HIPAA privacy rule.

____ ______________________________________

Signature of Client (or Parent if Minor) Date

____

Witness