Request/Authorization to Release Confidential Records and Information

I hereby authorize (person or facility) _____ located at: _____ Phone: _____

to release medical information about my treatment to Seth Bernstein, Ph.D.. He is my current psychotherapist. This information is to be provided for the purpose of assisting him in providing psychotherapeutic care to me.

The medical information to be released concerns my time in treatment with the provider named above between _____ and _____.

The specific content to be released includes:

- ❑ Intake and discharge summaries
- ❑ Medical history and evaluation(s)
- ❑ Behavioral health evaluations
- ❑ Developmental and/or social history
- ❑ Progress notes, and treatment or closing summary
- ❑ Other: _____

Method(s) of communication:

- ❑ Please forward the records to the address in the letterhead at the bottom of this form.
- ❑ Please call Dr. Bernstein to discuss.

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.

I have had explained to me and fully understand this request/authorization to release medical records/information, including the nature of the records/information, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Client Printed Name: _____ Signature _____ Date: ___/___/___

Client Address: _____ DOB: ___/___/___