Infinity Psychological Services, PLLC
Candice Waltrip, Psy.D.
Licensed Psychologist
3549 N. University Ave. #200
Provo, UT 84604
(801) 613-1048

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, authorize and request Dr. _____ of Infinity Psychological Services, PLLC, to release and/or obtain the following specific information pertaining to the treatment of _____ (Date of Birth: ____ /____/_____) to/from:

Person/Organization: _____

Street Address: _____

City/State/ZIP: _____

Telephone: _____ FAX: _____

Email: _____

I authorize Infinity Psychological Services, PLLC, to (check all that apply):

___ Exchange with ___ Release to ___ Obtain from the party listed above

I authorize Infinity Psychological Services, PLLC, to exchange/release/obtain information:

___ Verbally only ___ Written form only (including email) ___ Both verbally and in writing

Description of health information to be exchanged/released/obtained (initial all that apply):

_____Psychological Evaluation

_____All Progress Notes/Appointment Records

_____Treatment Summary

_____Medical History

_____School Records

_____Drug/Alcohol Records

_____Other:_____

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The specific purpose of this disclosure:

____ Coordinate Care/Treatment Planning

____ Transfer Care

____ Academic Planning

____ Legal Proceedings

____ Other:_____

I understand that my signature on this form is voluntary and that not signing will not affect the ability to receive treatment at this practice. I understand that this release will expire in **180 days**, unless revoked by me which I have the right to do at any time. I understand that any revocation will not apply to any PHI that has already been released in reliance to this authorization and to PHI created expressly for disclosure to the person/entity listed above. I understand that the PHI disclosed may be subject to re-disclosure by the person/entity receiving it and no longer protected by federal privacy regulations. I understand that any questions I have about the use or disclosure of this PHI can be directed to Infinity Psychological Services, PLLC at any time.

Signature: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

To the recipient of client records/information: This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal guidelines.

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