Kindelan McDanal & Associates

PSYCHOLOGICAL & COUNSELING SERVICES

Cynthia S. McDanal, PhD (Lic. # PY5297) | *Joel B. Freid, PhD (Lic. # PY2213)* | *Elizabeth Dumville, PsyD Postdoctoral Resident* | *Nickeisha Clarke, PsyD (Lic #PY9310)*

Lindsay Frey, PsyD Postdoctoral Resident | *Claudia Carrillo,JD,MS (Lic. # IMH12916)* | *Diana Amodeo, PsyD Postdoctoral Resident*

4729 US 98S, Suite #104, Lakeland, FL 33812
Office: (863) 877-1855 Fax: (863) 646-6111 Email: info@kindmcd.com

Authorization for Release or Exchange of Confidential Information

Patient: ______________________________ Date of Birth: ____________

I authorize **Kindelan McDanal & Associates** to ☐ release ☐ receive the following information (check all that applies):

_______ Results of psychological and/or educational testing
_______ Counseling/psychological treatment
_______ Medical information
_______ Educational
_______ Legal
_______ Psychiatric
_______ Other information (Specify: ______________________________)

I authorize **Kindelan McDanal & Associates** to exchange the specified information with the following entity:

Name/Agency: ______________________________

Address: ______________________________

Phone/Fax: ______________________________

Purpose of Disclosure:

_______ Continuing care
_______ At the request of patient/patient's parent or guardian
_______ Other (Specify: ______________________________)

This authorization shall remain in effect for one year from the signature date.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that **Kindelan McDanal & Associates** has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that **Kindelan McDanal & Associates** generally may not condition services upon my signing an authorization unless the services provided to me are for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

______________________________ ______________
Signature of Patient or Parent/Guardian of Minor Patient Date

______________________________ ______________
Print Name Relationship To Patient

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.