Sacks Clinical Consulting, P.C.
Request/Authorization for Release of Information

Client Name:_____
Address:_____
City, State and Zip Code:_____
Phone:_____ Birthdate:_____ Soc Sec:_____

I hereby authorize and request that the following persons and/or agencies:
Name:_____
Of_____
Address:_____
City, State and Zip Code:_____
Phone: ( )_____

- ☐ **Obtain** Information contained in my clinical records **from**_____
- ☐ **Release** Information contained in my clinical records **to**_____

For the purpose of:

- ☐ Assist with treatment planning or evaluation
- ☐ Client Request
- ☐ Billing Issues
- ☐ Other:_____

The information to be released :

- ☐ ALL OF BELOW
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Emergency Room Report
- ☐ Financial Information
- ☐ MRI, CT, EEG, Xray, SPECT, PET & evoked potential studies
- ☐ Inpatient or Outpatient Treatment Records
- ☐ Psychological/Psychiatric History and/or Evaluation(s)
- ☐ Neuropsychological scores, data or summaries
- ☐ Neuropsychological Test Reports
- ☐ Substance Abuse Facility Treatment Records
- ☐ Academic/Educational Records including achievement & other tests
- ☐ Other:_____

This consent may be cancelled (revoked) at any time to the extent that the health care provider(s) named above or custodian of the records has not already taken action in the reliance upon it. The authorization will automatically expire in six (6) months from the date it is signed.

This information is disclosed in accordance with Federal Confidentiality rules (42 CFR, Part 2), and HIPAA (45 CFR).

I hereby release the person or organization sending these records and results from any liability associated with administering, scoring, interpreting, evaluating, or reporting the results of these tests, I have read the above and acknowledge and understand the terms and conditions of this authorization.

Signature of Client	Printed Name	Date
Signature of parent guardian/representative	Printed Name	Date