

AUTHORIZATION TO RELEASE INFORMATION

CHARLES A. SCHAEFER, PH.D., INC.

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Name _____ DOB _____

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person(s) you designate.

I authorize the exchange of information between _____ and the following:

1. Name _____ Organization _____
Address _____ Phone _____
City _____ State _____ Zip _____

2. Name _____ Organization _____
Address _____ Phone _____
City _____ State _____ Zip _____

Extent of information to be released includes: _____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of _____.

This authorization will remain in effect for two years unless you designate a different time period below. You may revoke this authorization at any time by giving us written notice. I understand that I have the right to revoke this authorization at any time unless action has been taken in reliance upon it.

Expiration if different from above: _____

This authorization is fully understood and is voluntarily made on my part.

Patient's Signature

Date of Signature

Witnessed By: _____

OR

Parent or Legally appointed representative's signature

Relationship if not parent

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.