SPRING
PSYCHOLOGY

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RELEASE OF INFORMATION

I, ____________________, hereby authorize____________________and Spring Psychology to provide, obtain, and exchange information regarding my psychological state and/or history. I understand that this exchange of information is limited to the following individual or organization:

Name and Contact Information: ____

The following is what I would like released or obtained:

_____ Psychological Reports

_____ Diagnosis

_____ Billing-related Information

_____ Progress Notes

_____ Medical History/Medications

_____ Other:

I am, therefore, waiving my right to confidentiality as it pertains to the above information exchanged with the listed individual and/or organization. I understand that I may refuse to sign this authorization and my refusal to sing will not affect my ability to obtain treatment, make payment, or affect my eligibility for benefits. I have the right to revoke or cancel this authorization at any time, except to the extent information has already been shared based on this authorization. I understand that once information about me leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. I need to be aware that, at that point, my information may no longer be protected by HIPAA.

____

Name Signature Date

____

Witness Signature Date