Michael L. Stern, PhD

LICENSED CLINICAL PSYCHOLOGIST
CERTIFIED ADDICTION PSYCHOLOGIST

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Consent for Release of Information

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

I authorize my psychologist, Michael L. Stern PhD to release the information below to assist in my treatment.

____ Treatment records, including intake assessment, treatment progress, and discharge summary. Treatment occurred during the following period: _____.

____ Mutual exchange of information between Michael L. Stern, PhD and the below individual and/or agency as needed to assist in my treatment.

____ Other information: _____

____ Release excludes the following information: _____

The information is to be released only to:

_____

_____

_____

I am requesting my psychotherapist release this information for the following reasons: (if you do not desire to state a specific purpose, you may indicate "at the request of the individual")

_____

This release is valid for one year from date or until: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 treatment services are not contingent upon my decision concerning the signing of this release unless the services are provided to me 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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Date: _____

Patient Name: _____ SS# _____

Date of Birth:_____

Signed: _____

Parent/Guardian Signature: _____

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