

Request/Authorization to Release Confidential Records and Information

to release information from records about		· ·	•	
to release information from records aboutand whose Social Security number is				
☐ Further mental health evaluation, tr☐ Other:		ent planning		
These records concern the time between In the boxes below, the information to be of through them and, page numbers are indicated to the requester.	and and disclosed is marked by an X, the ite cated when appropriate. Written da	ems not to be released hates indicate when those r	ive a line drawn ecords were mailed	
☐ Intake and discharge summaries _	Medical history a	☐ Medical history and evaluation(s)		
☐ Mental health evaluations	Developmental a	☐ Developmental and/or social history		
☐ Educational records	Progress notes,	☐ Progress notes, and treatment or closing summary		
Other:				
☐ Please discuss verbally I have had explained to me and fully under the nature of the records, their contents, a entirely voluntary on my part. I understand extent that action based on this consent hat the date on which it is signed, or upon fulfi	nd the likely consequences and im I that I may take back this consent as already been taken. This conse	plications of their release at any time within 90 days nt will expire automatically	This request is s, except to the	
Signature of client	Printed name	Date		
Signature of parent/guardian/representative	Printed name	Relationship	 Date	
I witnessed that the person understood the physically unable to provide a signature.	e nature of this request/authorization	on and freely gave his or h	er consent, but was	
Signature of witness				

Dr. Diego Hernandez

Licensed Clinical Psychologist docdiego@earthlink.net 813-418-7868