catharine devlin Psy.D., S.C.
licensed clinical psychologist

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client Name:	Date of Birth:
Address:	Telephone Number:

I hereby authorize and consent __**Catharine Devlin, Psy.D.**__ to release *and* exchange written, oral or electronically transmitted protected health information, indicated below, related to the above named individual with:

Provider Name/Organization/Individual: _____

Full address of Provider/Organization/Individual_____

City: _____ State: _____ Zip Code_____ Telephone #: _____

Including information related to: __ Mental Health Care & Treatment __ Substance Abuse Care & Treatment __ Medical Care & Treatment __ School Records

For the following purpose(s): ___ Legal Purposes ___ Follow-up Care ___ Case Consultation/Collaboration ___ Insurance Determination ___ Referral
___ Continuity of Care ___ At Request of the Individual ___ Family Therapy ___Other(Specify)_____

Valid From: _____ Expiration Date or Event: _____

INFORMATION TO BE DISCLOSED:

____ Progress Notes ____ Laboratory Results ____ Treatment Progress

____ Dates of Treatment ____ Therapy Attendance ____ Psychiatric Diagnosis ____ Psychosocial History ____ Consultation
____ Discharge Summary ____ Medical History ____ Medication Information ____ Psychosocial Assessment ____ Psychological Evaluation
____ Other(Specify) _____

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to Catharine Devlin, Psy.D.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information may not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.
- The Consequences of my refusal to sign, if any are:_____

_____ _____ _____ _____
(Signature of patient) (Date) (Signature Parent or Legal Representative) (Date)

_____ _____
(Witness Signature) (Date)

(Patients 12 to 17 years of age must sign in addition to the Parent or Legal/Personal Representative)
(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
Fees/charges will comply with all laws and regulations applicable to release protected health information.