PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

aspen

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential MENTAL HEALTH information and records.

AUTHORIZATION

I hereby authorize: Karen P. Williams, Ph.D.
(Licensed Psychologist)

To release / obtain information of

_____(Patient's Name)

_____(Patient's DOB) regarding my MENTAL HEALTH illness, treatment, diagnosis or prognosis, and/or other mental health information by means of mail or fax

To / From:
Name_____

Address_____

_____

Phone:_____ Fax:_____

The medical information/records will be used for the following purpose:
[ ] Continuity of care
[ ] Other:_____

I have been advised of my right to receive a copy of this authorization.
DURATION: This authorization shall remain valid until_____

_____ _____
Signature: Patient/representative Print name SS#

Date: _____ Relation:_____

Rev Aug 2015