

# Mielke and Weeks Psychological Services

## Authorization for Release of Information

### Client

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Mielke and Weeks Psychological Services to disclose the following: (check appropriate choices).

\_\_\_ Release of written information to party named below, which includes, but not limited to complete provider clinical record (i.e., biopsychosocial assessment, treatment planning, diagnoses, therapy notes, psychological testing, medication reviews, and summary of treatment.

\_\_\_ Consultation and verbal exchange of information between Mielke and Weeks Psychological Services and party designated in the following section.

The aforementioned actions described above are authorized to be released to/with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Authorization

I authorize Mielke and Weeks Psychological Services to release the information indicated above. I understand that this authorization is voluntary. In addition, I understand that my records are protected under federal regulations including alcohol or substance abuse, as well as information protected under regulations in code 42, part 2, psychological service records, social service records, HIV communicable disease information, including communications between mental health provider and you. Upon release, this health information is no longer protected by Mielke and Weeks Psychological Services and has the potential to be re-disclosed by the recipient. This authorization does not authorize Mielke and Weeks Psychological Services to discuss my health information or medical care with anyone other than the individual or agency identified on this form. **Mielke and Weeks Psychological Services is released from all legal liabilities for the release of the above requested information.** I understand that this authorization will be in effect for twelve months from the date signed unless cancelled by me in writing, and that my cancellation will take effect when the individual or agency releasing information receives my notice in writing.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date