



Adeline Tryon, PhD, Licensed Psychologist
Samantha Scott, PhD, Licensed Psychologist
& Associates

Release of Information

Contact Information

Client Name: _____ Client Date of Birth: _____
Contact Phone Number: _____ Contact Email: _____
Client Address: _____
(Street Address) (City) (State) (Zip)

Authorization

I authorize The Child and Family Center to (check one):

Release the information indicated to:

Request the information indicated from:

(Name of Person or Entity to receive or disclose information)

(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

Email: _____

Information Requested

Dates of Records Requested: _____

Medical Records/History
Previous Evaluations
IEP/504 and any school accommodations
Progress Notes and Treatment or Closing Summary
Speak with Therapist/Teacher/School Personnel

Substance Use Disorder Records
Developmental and/or Social History
Educational Records
Complete Assigned Rating Forms
Other: _____

Acknowledgement

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosure already made in reference to this authorization.

I understand that this disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.

I understand that substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Client or Authorized Representative (Signature)

Date

Client or Authorized Representative (Print Name)

Relationship to Client