Center for Anxiety & Social Intervention

Evidence-based psychotherapy and assessment
for children, teens, and families

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AUTHORIZATION TO RELEASE/RECEIVE CLINICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize our psychologist Glen Veed, Ph.D. to release and receive healthcare information from the clinical record of the patient named above to/from:

Name (of individual or organization/facility): _____

Address: _____

Phone: _____

This request and authorization applies to (please check one or more):

- □ Verbal Discussion of Case
- □ Psychological Testing Reports
- □ Treatment Summary
- □ Hospital/School Records
- □ Office Psychotherapy Notes
- □ Other_____

The purpose of this authorization is (are): is request and authorization applies to (please check one or more):

- □ At the request of the individual/guardian
- □ Coordination of psychological treatment
- □ Other_____

This authorization will expire on: _____

- You have the right to revoke this authorization at any time by sending written notification to the office address. However, your revocation will not be effective to the extent that the provider has taken action in reliance on the authorization prior to receiving your notice of revocation.
- I understand that the provider may not condition the provision of psychological services upon my signing an authorization.
- I understand that I have the right to inspect the disclosed mental health information at any time.
- I understand that Illinois law prohibits the re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

Patient Signature: _____ Date : _____

Parent/Guardian Signature (if applicable): _____ Date : _____