

Cornerstone Psychological Associates, PLLC

1755 Westgate Dr., Ste. 260, Boise, ID 83704 ♦ (208) 373-0790

Authorization for Release of Confidential Information

Name: _____ D/O/B: _____

Address: _____

I, _____, authorize Cornerstone Psychological Associates, PLLC. to
 disclose to or to request from, Name: _____ Phone: _____

These records concern the time between _____ and _____

The following information: <input type="checkbox"/> All Mental Health Records
Or, mark one or more of the following: <input type="checkbox"/> Mental Health Record Summary <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Psychotherapy Notes <input type="checkbox"/> Other (Specify) _____
The purpose or need for such disclosure: <input type="checkbox"/> Ongoing Treatment/Diagnosis/Treatment Plan <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Legal Issues <input type="checkbox"/> Other (Specify) _____

I understand that my records are protected under Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient and may no longer be protected by state and federal privacy laws.

I also understand that I may revoke this consent in writing at any time, except to the extent that action based on it has already taken place, by contacting the Agency at the address above. This consent automatically expires 6 months after my termination from the Agency program

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The information authorized for release *may include* drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42CFR part2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42CFR part 2. A general authorization for the release of medical information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my record to be released, unless I have crossed it out and initialed it. Yes No _____ Initials

This consent is in effect until one year from date of signature, or as specified _____. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

Client/Parent/Legal Guardian: _____ **Date** _____

Relationship to patient: _____