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Authorization for Release of Information

Name of Client : _____

Social Security Number (last 4 numbers): _____

Date of Birth: _____

I, _____, authorize Jason E. Wilson, LPC, and/or any member of REDEFINE Psychological Services staff to _____exchange with, _____ disclose to and/or _____ obtain from:

_____
Name of Individual and/or Organization

_____
Address, Phone Number, Facsimile Number

the following information:

_____ Social History
_____ Medical Records
_____ School Records
_____ Other (specify) _____

_____ Discharge Summary
_____ Legal Status/History
_____ Diagnostic Evaluation

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without written consent unless otherwise provided for in the laws and regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent will automatically expired at/on:

Date or condition upon which this consent will expire: Upon completion of service(s).

Signature of Client: _____ Date: _____
Signature of Client/ _____ Date: _____
Legal Guardian _____ Date: _____