

Authorization for Release of Psychiatric/Psychological Records

Client Information:

(First) (Last)

(Date of Birth) (SS#)

(Indicate Previous Name(s) Used, If Any)

(Address)

(City, State, Zip)

(Phone) (Fax)

Name or Institution Information to be released to:

(Name)

(Address)

(City, State, Zip)

(Phone) (Fax)

I hereby authorize the Behavioral Medicine Institute of Atlanta to do: (Check appropriate box).

- | | |
|--|---|
| <input type="checkbox"/> Exchange Records With | <input type="checkbox"/> Exchange Information with Polygraph Examiner |
| <input type="checkbox"/> Phone Contact Only | <input type="checkbox"/> Other _____ |

Purpose or need for disclosure: (Check those that apply)

- Assessment and/or Treatment Coordination
- Polygraph Examination
- To Process Insurance Claim
- Other (Specify) _____

Specific Information to Be Disclosed:

- Intake evaluation; Therapy notes; Psychiatric evaluation; Psychological testing/evaluation and/or Medical records
- Probation/parole records
- School behavior records
- Polygraph Report
- Other (Specify) _____

Signature of Client _____ **Date:** _____

Signature of Authorized Person: _____ **Date:** _____

If signed by person other than client, state authority to do so below:

Legal Authority: Legal Guardian Parent of Minor Next of Kin Power of Attorney

Signature of Witness: _____ **Date:** _____

A SIGNED FAX WILL SERVE AS AN ORIGINAL RELEASE