Center for Psychology And Learning

Assessment, Therapy & Consultation

Child Authorization Form

This form when completed and signed by you, authorizes Center for Psychology and Learning to release protected information from your child's clinical record to the person you designate.

I authorize the Center for Psychology and Learning, including Dr. Dana Osowiecki, Dr. Natalia Mieczynski, and/or administrative and clinical support staff to release and to receive verbal and written information regarding Neuropsychological/ Psychological Evaluations, Therapy, or Consultation Services for my child, _____.

This information should only be released to parties listed below. If this evaluation is being paid for by a school district, they must be included on this release form.

_____

Name of Agency | Name of Contact Person

_____

Address | Phone Number

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

____ At the request of the individual

_____

This authorization shall remain in effect for six months following the date of evaluation unless otherwise specified. Date of Evaluation/Consultation: ____/____/____ Release Expiration Date: ____/____/____

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining payment and the third party payer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I also understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____

Signature

_____

Print Name

_____

Date

_____

Relationship to Child