Conditt
Psychological Services

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient)** _____, (hereinafter "Patient") hereby authorize (circle) **Paul M. Conditt, Psy.D. or Kristine M. Conditt, Ph.D.** , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

_____(name of person receiving released information)

_____(contact information of person receiving information)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **Conditt Psychological Services** to be effective.
This disclosure of information and records authorized by Patient is required for the following purpose: Coordination of care with my primary care physician / other professional entity.
The specific uses and limitations of the types of medical information to be discussed are as follows: whatever information is needed for coordination of care.
Such disclosure shall be limited to the following specific types of information: symptoms, treatment plan, progress, prognosis, diagnosis, any other information needed for coordination of care.
Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.
Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.
This authorization shall remain valid until: _____or end of therapy.

Patient's signature _____**Date**___/____/_____

Signature of Parent/Guardian/Conservator:_____**Date**___/____/_____

Or
I do not want any information released to my primary care physician or I do not have a primary care physician.

Patient's signature_____**Date**____/____/_____

Signature of Parent/Guardian/Conservator:_____**Date**____/____/_____