Ψ TREASURE VALLEY PSYCHOLOGICAL SERVICES

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Ronald B. Tye, PsyD — Licensed Clinical Psychologist, Clinical Director
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AUTHORIZATION TO RELEASE INFORMATION

I, _____, legal guardian of _____, hereby give permission to Treasure Valley Psychological Services and/or the practice administrative and clinical staff, to **disclose/obtain:**

☐ **ENTIRE RECORD**
or
☐ OTHER ITEM: _____
(Specify Item)

☒ **TO: /** ☐ **FROM**:

_____ _____
Name of physician, attorney,counselor, etc. Telephone Number

_____ _____
Street Address Fax Number

_____
City, State and Zip

I am requesting the release of this information for the following reason:

☒ at the request of the individual. (Select if you do not desire to state specific reason.)
or
☐ (state specific reason) _____.

The time frame within which this Release of Information is applicable is: _____ to _____. I may revoke, in writing, this consent at any time to the extent that action has been taken in reliance upon it.

I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, you must provide to me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

_____ _____
Signature of patient or authorized representative Date

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any alcohol or drug abuse patient.