Insight Psychological Services
2126 Richmond Highway
Suite 103
Stafford, VA 22554
Phone: 540-658-0888 Fax: 540-658-0855

RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

I authorize _____ to use or disclose the following: (check one)

- o Academic assessment results
- o Behavior programs
- o Progress reports
- o Intelligence assessment results
- o Medical reports
- o Personality profiles
- o Psychological reports
- o Psychological assessment results
- o Service plans
- o Summary reports
- o Vocational testing results
- o Entire record except progress notes
- o Psychotherapy notes
- o Other:_____

The Authorized Party has my authorization to disclose Medical Records to:

Name: _____

Address: _____

Phone: _____ Fax: _____

The reason for this authorization is: (check one)

- o Planning appropriate treatment or program
- o Continuing appropriate treatment or program
- o Determining eligibility for benefits or program
- o Case review
- o Updating files
- o Other: _____

I understand that I have the right to revoke this authorization, in writing and at any time, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy or Individually Identifiable Health Information, parts 160 and 264) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, part 2) in addition to applicable state laws. I furthermore understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal laws.

Your relationship to the patient: Self Parent/legal guardian Personal representative Other:_____

If you are the legal guardian or representative appointed by the court for the patient, please attach a copy of this authorization to receive the protected health information.

Patient Signature: _____ Date: _____