The Haymount Institute for Psychological Services

Consent for the Release of Confidential Information

Applicable Under Federal Law 42 CFR Part 2

Client's Last Name: _____ First: _____ DOB: ____/____/_____ SSN: ____-___-____

I authorize the following organization and/or individual to release/exchange information with The Haymount Institute:

Name of Agency and/or Individual: _____ Relationship & Title: _____
Phone Number: _____Fax Number: _____ Address: _____

I voluntarily authorize and request disclosure (including paper, oral and electronic interchange) for the* purpose *of: (please* initial *all that apply)

____ Insurance Payment ____ Disability Determination ____ Legal Purposes ____General Verbal Information
____Discharge Planning/ Coordination of Care ___ Other: _____

The following information is the only authorized information to be exchanged; (please* initial *all that apply)

____ Clinical Intake ____ Discharge Summary ____ Progress Notes ____ Psychological Testing Reports
____ Face Sheet (s) ____ Medication Records ____ Referral & Appointment Dates ____ Behavioral Plan
____ All Legal Documentation ____ Psychiatric Assessment ____ Substance Abuse Information
____ HIV/AIDS/Communicable or non-communicable disease ____ Labs ____ Other: _____

I hereby request and authorize the above named agencies, organizations or individuals that possess information relative to the agency, organization or individual name on the request. I understand that this release may include information regarding the following: Psychological or psychiatric information, substance abuse, drug abuse, and/or alcoholism, records which may indicate the existence of a communicable or non-communicable disease, and records pertaining to HIV/AIDS.

By requesting a copy of my confidential psychological report, I understand that the information contained will be released at the discretion of the psychologist, and may contain either the full report findings or an abbreviated report of findings as deemed appropriate by the psychologist. Release of a psychological report does not automatically imply access to all mental records, since such records would be released at the discretion of the clinician providing services outside of the scope of the psychological testing. I also understand that once the report is released to me, I become solely responsible for the security of the findings.

I understand that the information to be released is protected under the state and federal law and cannot be disclosed without further written consent by me, unless otherwise provided for by state or federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire 365 days from the date it is signed, or automatically one year from the date it is signed.

_____ _____
Date **Signature of Client**

_____ _____
Date **Signature of Guardian/or Authorized representative**

_____ _____
Date **Witness**

_____ _____
Date **Second Witness (if phone consent)**