Lindsay A. Solomon, Psy.D., LLC
Licensed Psychologist

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Lindsay A. Solomon, Psy.D., LLC to release or obtain information from my medical, educational, psychiatric, substance abuse records.

INFORMATION MAY BE RELEASED TO OR OBTAINED FROM:

Name of Person or Agency: _____Phone: _____

Mailing Address: _____

INFORMATION TO BE RELEASED/OBTAINED:

_____ Admission History & Medical Status Exam
_____ Psychological Evaluation
_____ Psychological Assessment
_____ Treatment Plan
_____ History & Physical
_____ Consultation
_____ Education Evaluation/Records
_____ Medication Records
_____ Progress Notes
_____ Discharge Summary
_____ Verbal Information exchange as needed
_____ other (specify) _____

FOR THE FOLLOWING PURPOSE: _____

The consent is given freely and voluntarily. Any information shall not be released by the recipient without written consent except as mandated by state and federal law. In the event that information is released by a third party to unauthorized persons, the undersigned hereby releases Lindsay A. Solomon, Psy.D., LLC from any and all liability for such unauthorized release of information.

IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART2):
I hereby also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

I, the undersigned, understand that I may revoke this consent any time except to the extent that action has been taken and that in any event this consent shall expire 60 days after the date of discharge unless another date is specified. For reimbursement purpose, this authorization shall remain until full reimbursement for services has been received.

Specifications of the date, event or condition upon which this consent expires: _____

_____ Client's Name

_____ Client's Date of Birth

_____ Client's Signature

_____ Date

If Applicable:

_____ Signature of Parent/Legal Guardian

_____ Date

_____ Relationship

_____ Signature of Witness (Date)

PROHIBITION OF REDISCLOSURE: This information is being disclosed to you from records whose confidentiality is protected by law. Further disclosure of this information, except with the specific written consent of the person to whom it pertains, is prohibited.

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