Authorization for Disclosure of Medical, Clinical and Educational Information

Re: _____ D.O.B.: _____

1. I am _____ the person legally responsible for the above named client
   _____ the client

2. I authorize John W. Steele, Ph.D. to
   _____ obtain information from _____ release information to

   Name of Person or Facility: _____

   Address: _____

   City, State, Zip: _____

   Fax: (___)_____Phone: (_____)_____

   Email _____

3. I authorize the disclosure of protected health information by
   _____ fax _____ oral _____ written _____ email

4. Specific information to be released or obtained:
   _____ all necessary medical information (e.g., medical history, lab tests, diagnosis)
   _____ all information necessary for clinical treatment (e.g., psychiatric, psychological evaluations, treatment plans)
   _____ all necessary school/educational information (e.g., report cards, IEP, test reports, permanent record, CSE minutes)
   _____ other: _____

5. This information is necessary for ongoing medical, clinical and educational purposes including evaluations and treatment recommendations.

6. I understand that I have the right to revoke and/or restrict this authorization at any time provided that I submit a request in writing. Any revocation shall not apply to actions already taken in reliance on this authorization.

7. I understand the information disclosed as permitted by this authorization may be re-disclosed and may no longer be protected by the HIPAA Privacy Rule.

8. I have been informed that school records are "open" records and may be reviewed by anyone having access to school records and may be shared without my knowledge or permission.

9. I authorize the periodic, ongoing disclosure of the above information until (fill in expiration date) _____ or until (fill in an event that relates to the individual or purpose of the disclosure)
   _____

   Client/Parent/ Guardian Signature: _____ Date: _____

   Client/Parent/Guardian Print Name: _____

   Relationship to Client: _____

   Witness: _____ Date: _____

   Information sent: _____

   Date sent: _____

John W. Steele, Ph.D., Licensed Psychologist
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