

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

Facility/Name: _____
Address: _____
City, State, Zip: _____
Fax: () _____ Phone: () _____
3. I authorize the disclosure of protected health information by
_____ fax _____ oral _____ written
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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