**RENÉ J. BRITT, PH.D.**
**PSYCHOLOGICAL ASSOCIATES, LLC**
**1915 Professional Circle, Auburn, Alabama 36830**
**Ph: (334) 826-1699 Fax: (334) 826-1629**

## CLIENT AUTHORIZATION TO RELEASE INFORMATION

Client Name _____ SSN _____

Dates of Service _____ Birthdate _____

I authorize my Psychological Associates, LLC, and/or its administrative and clinical staff to release / obtain the following information (check all applicable boxes):

- ☐ Release psychological treatment records
- ☐ Release psychological testing records
- ☐ Obtain medical / psychiatric treatment records
- ☐ Obtain medical / psychiatric testing records
- ☐ Obtain psychological testing / treatment records
- ☐ Obtain educational testing / assessment records
- ☐ Other _____

This information should be released to/obtained from:

Name _____

Address _____

_____

I am requesting Psychological Associates, LLC, to release/obtain this information for the following reason:

_____

This authorization shall remain in effect until _____ (date)

or until _____ (event)

By signing below, I agree to these conditions:

- I have the right to revoke this authorization at any time by sending a written request to Psychological Associates, LLC. However, my revocation will not be effective to the extent that Psychological Associates, LLC may have already taken action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurance provider has a legal right to contest a claim.
- Psychological Associates, LLC may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client _____ Date _____