Authorization to Release Confidential Information Form
Dr. Shalena Heard

A. I, _____, Date of Birth: ___/____/_____, Social Security #_____, understand that the purpose of this release is to assist with the above named patient's assessment by improving communication between professional service providers or agencies and the important individual(s) in the patient's life.

B. To further this goal, I authorize the individual or agency listed below to (Check all that apply):
   - ☐ **Release** the following specified information regarding the above named patient in any format, including by telephone.
   - ☐ **Receive** the following specified information regarding the above named patient in any format, including by telephone.
   - ☐ **Release AND Receive** the following specified information regarding the above named patient in any format, including by telephone.

   I have been informed of the risks to privacy of the use of electronic means of information transfer, and I accept these.

C. The information to be disclosed is marked by an X in the boxes below:
   - ☐ Health history and treatment
   - ☐ Mental health history and treatment
   - ☐ Substance use history and treatment
   - ☐ All health, mental health, and substance use history and treatment
   - ☐ Other (please specify): _____
     _____

D. This information is to be disclosed and/or obtained from the following person or agency listed below:

   Name: _____

   Agency: _____

   Address: _____

   Telephone Number(s): _____

   Fax Number(s): _____

   Email address: _____

E. I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire (Select one):

- ☐ 1 year from this date
- ☐ Upon my discharge from treatment by this agency or the person specified above
- ☐ Under these circumstances (Please specify): _____
  _____

F. Signatures:

_____	_____
Patient's Name Printed	Date
_____	_____
Patient's Signature	Date
_____	_____
Parent/Guardian/Representative's Name Printed	Date
_____	_____
Parent/Guardian/Representative's Signature	Date
_____	_____
Shalena Heard, Ph.D. Licensed Psychologist (#05613)	Date