FILASKI PSYCHOLOGICAL CARE, P.C.

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MEDICAL RECORDS RELEASE FORM

1. I hereby authorize_____to release my information to:

   Name:_____

   Address:_____

2. Patient's Name:_____

   Address:_____

   Date of Birth:_____Phone:_____

3. The purpose for which the following information is being requested:_____

4. I authorize the following information to be released from my psychological health records:

   Starting date:_____

   Psychological/Mental Health Records that are authorized to be released:

   - ☐ History and Behavioral Notes
   - ☐ Diagnostic Evaluations and Tests
   - ☐ Progress Notes**/** Discharge Summary
   - ☐ Treatment Plan

5. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon authorization. I further understand that no treatment, payment, or eligibility of benefits may be conditioned on whether I sign this authorization. The provider is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I am entitled to a copy of this authorization.

Printed Name:_____

Patient/Parent/Guardian Signature:_____ Date:_____

Relationship to Patient:_____