**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Amy Mozolik, PsyD, at 10501 E Seven Generations Way, Ste 121, Tucson AZ 85747 to (send) ⬜ (receive) ⬜ the following records (to) ⬜ (from) ⬜ the following agencies or people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address City/State Zip Phone

**Please INITIAL**:

⬜ Academic Testing Results ⬜ Neuropsychological Testing Results

⬜ Psychological Testing Reports ⬜ Vocational Testing Reports

⬜ Progress Notes ⬜ Treatment Plans

⬜ Medical Reports ⬜ Intake/Discharge Summaries and Reports

⬜ Progress Reports ⬜ Entire Record

⬜ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be released via **(Please INITIAL)**:

⬜ Verbal Exchange ⬜ Fax

⬜ Mail ⬜ Email (may be unsecured)

⬜ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be used for the following purposes **(Please INITIAL)**:

⬜ Treatment Planning ⬜ Case Review/Consultation

⬜ Continuity of Treatment/Care ⬜ Academic Purposes

⬜ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information disclosed will include details related to my mental health, and may include alcohol/substance abuse records or HIV status information. I understand I have the right to revoke this authorization, in writing, at any time by delivering such written notification to Amy Mozolik, PsyD. However, my revocation will not be effective to the extent that I have already taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage. This release will automatically expire one year from date of signature. I have been informed to whom it will be given, its purpose, and who will receive the information.

I understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by privacy laws.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian (if applicable) Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date Printed Name