Anxiety & OCD Center

Dr. Erwin Consulting®

Authorization for Release of Information

Name: _____ Date of Birth: _____

I hereby authorize all Anxiety and OCD Center clinicians to release the following information (check all that apply):

_____ No restrictions apply

_____ Oral or written summary of presenting difficulties, background information, and course of therapy, including dates of sessions and diagnoses

_____ Other:_____

To the following individual, agency, school, or institution:

_____

_____

I understand that the confidentiality of these records is protected by federal and state law and that they cannot be released except as indicated above without my written consent unless special circumstances as authorized by laws governing release of information are applicable.

I understand that this authorization will remain in effect until (fill in expiration date or an event that relates to the individual or the purpose of this disclosure)_____and that I may withdraw my consent at any time (except for action already taken) by written request to the person/clinic from which records have been requested.

I understand that my therapist generally 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.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____

Signature Date

_____ _____

Signature of parent or guardian if person is under age 14 or declared legally incompetent Date