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AUTHORIZATION FOR RELEASE OF INFORMATION

This form, when completed and signed by you, authorizes Roger A. Olsen, PsyD, LP to release protected health information about you or your child.

Client's Name: _____

Client's Date of Birth: _____

Client's Address: _____

Client's Telephone Number: _____

I authorize Roger A. Olsen, PsyD, LP to release and obtain the following information:

- ☐ Entire Record
- ☐ Verbal information (two-way)
- ☐ Psychological Evaluations
- ☐ Progress to Date
- ☐ Treatment Plans/Summaries
- ☐ Diagnosis
- ☐ Frequency of Treatment Received
- ☐ Type of Treatment Received
- ☐ Other _____

This information is being released for the purpose of _____.

This information should only be released to or obtained from (circle appropriate) the following person/s:

Name: _____

Title: _____

Address: _____

_____

Phone: _____

This authorization shall remain in effect until _____ (date).

I understand that I have the right to cancel this authorization, in writing, at any time by sending or giving such written information to my psychologist. However, my cancellation will not be effective to the extent that my psychologist has already taken action relying on this authorization. I understand that information used or disclosed that is related to this authorization may be subject to re-disclosure by the recipient of the information and is not longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Guardian Date

Authority of personal representative or guardian to act on behalf of the patient: _____