RELEASE AUTHORIZATION FORM

KATHY WAGNER COUNSELING SERVICES, LLC

111 Petrol Point Drive, Suite 102
Peachtree City, GA 30269

This form, when completed and signed by you, authorizes me to RELEASE or OBTAIN protected information from your clinical record to the person you designate.

Client's Name: _____ DOB: _____
(Print name)

I authorize Kathy Wagner, LPC and/or her administrative or clinical staff

to RELEASE:
- [ ] Report of Psychological Evaluation
- [ ] Clinical Information via telephone – Specify: _____

to OBTAIN:
- [ ] History & Physical, Emergency Room and Intake Evaluation Report(s)
- [ ] Office, Hospital and Progress Notes – Specify: _____
- [ ] Laboratory Report(s) – Specify: _____
- [ ] EEG, MRI, PET, MRA and CT Scan Report(s)
- [ ] Clinical Information via Telephone – Specify: _____
- [ ] Academic Records, including Grade Reports, Achievement and Scholastic Aptitude Test Results and Behavioral records for period: _____

This information should be RELEASED to / OBTAINED from: _____

Address: _____ Phone: _____

_____ Fax: _____

I am requesting Kathy Wagner, LPC to RELEASE or OBTAIN this information for the purpose of:
- [ ] Psychological Evaluation
- [ ] Treatment coordination and/or planning
- [ ] Disability Determination
- [ ] Other – Specify: _____

This authorization shall remain in effect no longer than 365 days or until _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest claim. I understand that my psychologist 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 HIPAA Privacy Rule.

_____ _____
Client Signature Date

_____ _____ _____
Client Representative or Guardian Signature (Relationship to client) Date

_____ _____
Witness Signature Date