

Gibson Psychological Services LLC

Authorization for the Release of Confidential Information

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person or entity you designate. You may also permit me to obtain information from another person or agency.

I, _____, (date of birth) _____,

authorize Andrew S. Gibson, Ph.D., to

Provide information to **Person or Agency:** _____

Receive information from **Address:** _____

Phone: _____

Fax: _____

The information being released includes:

confirmation of services received Diagnosis

treatment history/progress update Treatment Referral

HIV/AIDS related records Intake/Termination/Treatment summary

All records Other: _____

Purpose of release of information:

documenting receipt of services continuity of care

safety planning/risk management

intake/termination/treatment other: _____

This authorization will remain in effect for one year of sign date or until: _____

By signing this you understand that you have the right to revoke this authorization, in writing, at anytime by sending notification to the office address of Gibson Psychological Services LLC. Note that this revocation will not be effective if the authorization was obtained as a condition of insurance coverage and the insurer has a legal right to the claim, and that it will not be effective for actions taken prior to the requested revocation. You have also been made aware of your right to confidential communication with your psychologist. I understand that information used or disclosed as indicated in this release may be subject to nondisclosure by the recipient of your information and is no longer protected by privacy laws.

Printed Name of Client

Date of Birth

Signature of Client

Date

Signature of Parent/Guardian (if applicable)

Date