ROBYN'S N.E.S.T. PSYCHOLOGY
NURTURING EMOTIONAL SUCCESS TOGETHER

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Consent for Release of Treatment Information

Date: _____

The following information pertains to _____ [*Client*], DOB_____

I, _____ [*Client/Guardian*], authorize **Robyn's N.E.S.T. Psychology** to ***disclose*** and/or ***obtain*** information from:

_____ [*Person/Organization*].

Information authorized to disclose or obtain:

**Client/Guardian should initial each item to be disclosed*

_____ Assessment
_____ Diagnoses
_____ Psycho-social Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes (*not to be combined with any other disclosure)

_____ Other _____

_____ Other _____

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

_____

_____

_____

_____

_____

Revoking Authorization/Expiration

I, _____ [*Client/Guardian*], understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to *Robyn's N.E.S.T. Psychology* [contact information at start of form]. I further understand that a revocation of the authorization is not effective for any acts or information obtained prior to signed revocation. Unless sooner revoked, this authorization expires on the following date: _____, or expires automatically one year from today.

Conditions

I further understand that *Robyn's N.E.S.T. Psychology* will not refuse treatment if I choose not to give authorization for the requested disclosure. I understand that failure to sign this authorization may limit the extent to which services may be provided in some instances due solely to safety of the client. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand the potential that the afore mentioned protected health information disclosed and agreed to above within this authorization may be re-disclosed by the recipient and may no longer be considered protected by the HIPAA privacy regulations, unless a State law applies to that person/organization that is equal or as strict as HIPAA and provides additional privacy protections.

_____

(Signature of Client/Guardian) (Date)

_____

(Printed Name) (Relationship to Client)

_____

(Signature of Staff Witness) (Date)

_____

(Staff Printed Name) (Staff Title)

You will be given a copy of this authorization for your records. **RobynsNestPsychology.com**