Terasa L. Davis, Psy.D., PC

Authorization for Release of Information

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_____ _____

Client Name Date of Birth

AUTHORIZES: ☐ Release to ☐ Obtain from ☐ Mutual/Two-way release between

TERASA L. DAVIS, PSY.D., PC
300 TOWNCENTER BOULEVARD, SUITE C
Tuscaloosa, AL 35406
(205) 391-9777
(205) 391-9766

_____
Agency/Program/Person

_____
Address/City/Zip

Phone: ( ) Fax: ( )

I understand that the specific type of information to be disclosed includes: Dates of service to include: **_____ to _____**

☐ **ALL OF BELOW**

☐ Mental Health Records	☐ Psychiatric Reports	☐ Psychological Report(s)
☐ Medical Records	☐ Discharge Summary/Plan	☐ School Records, including attendance
☐ Medications	☐ Diagnosis	☐ Prognosis
☐ Progress Notes	☐ History & Physical	☐ Inpatient/Outpatient treatment records
☐ Consultations	☐ Emergency Room Report	☐ Other: _____

The purpose of need for this disclosure is: (Check all that apply)

☐ Consultation	☐ Transfer of Care	☐ Client Request
☐ Continuation of Care	☐ Legal Purposes	☐ Insurance Purposes
☐ Other: _____		

This authorization includes consent to release information verbally from these records: ☐ YES ☐ NO ☐ Other: _____

Expiration Date of this Authorization: If not previously revoked, this consent will terminate **90 days after last seen OR:**
☐ after the above information is released ☐ on specific date _____ ☐ on specific event _____

I understand that this authorization is voluntary and I need not sign this form in order to assure treatment. **I also understand that I have the right to inspect and/or receive a copy of the information to be disclosed if I sign a separate authorization to myself to receive a copy. I understand that the information I authorize to be released may be re-disclosed by the recipient for the records only if allowed by law and that **I have the right to revoke this authorization, in writing at any time by contacting my therapist at (205) 391-9777.**

By signing this form, I attest that I understand and agree with the content of this form.

YOU MAY REFUSE TO SIGN THIS FORM

A COPY IS AS VALID AS THE ORIGINAL

_____ _____
Client Date

_____ _____
Parent/Legal Guardian/Authorized Representative Date

_____ _____
Witness/Relationship/Department Date

For Office Use:

☐ ID Verified