

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
661 HELEN KELLER BOULEVARD, SUITE B
Tuscaloosa, AL 35404
(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

- | | | |
|--|---|---|
| <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> Psychological Report(s) |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Discharge Summary/Plan | <input type="checkbox"/> School Records, including attendance |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prognosis |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Inpatient/Outpatient treatment records |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Other: _____ |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Client Request |
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Insurance Purposes |
| <input type="checkbox"/> 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.

Client

Date

Parent/Legal Guardian/Authorized Representative

Date

Witness/Relationship/Department

Date

YOU MAY REFUSE TO SIGN THIS FORM

A COPY IS AS VALID AS THE ORIGINAL

For Office Use:

ID Verified