# Authorization for Release of Information

## Memory & Psychological Services, Inc.

Name: _____ Date: _____

DOB: _____/_____/_____ SSN#: _____/_____/_____

I authorize Memory & Psychological Services, Inc. to: _____ Release To _____ Obtain From

Name: _____

Phone: _____ Fax: _____

Address: _____
Address City State Zip Code

I authorize the release of the following information **BY** Memory & Psychological Services, Inc.:
____ Summary of Treatment (including diagnosis, number of sessions attended and progress)
____ Psychological Testing Results (may include a written report)
____ Other: _____

I authorize the release of the following information **TO** Memory & Psychological Services, Inc.:
____ Summary of Treatment (including diagnosis, number of sessions attended and progress)
____ Testing Results
____ Medical Records
____ Other: _____

For the Purposes of: Continuity of care _____
Information Requested By: _____
Expiration: _____/_____/_____ (Cannot exceed one year from signature date)

I expressly consent to the release of information designated above. I understand that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness, alcohol/drug abuse, and/or Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis.

I understand that I have the right to shorten the authorization period or to revoke this authorization at any time. However, the revocation must be in writing, addressed to Jody Pickle, PhD. I also understand that if I choose to revoke this authorization, Jody Pickle, PhD may have already released the above information in reliance on my original decision. In addition, the information that I have authorized Jody Pickle, PhD to release to another entity may be subject to re-release by the recipient and no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164).

I understand that my refusal to sign this authorization will not condition treatment or payment of services.

_____ _____ _____
Client or Representative Date Relationship to Client

**PO Box 634**
**Aurora, Ohio 44202**
**(440) 546-0048**
***** Fax (888) 828-2326 (preferred if possible) *****