**Sun Prairie Psychological Services**
**705 West Main Street, Suite 3**
**Sun Prairie, WI 53590**
**(608)825-6663**

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

I hereby authorize: Name:_____
To release information regarding
and/or received information about: Name:_____
Birth Date: _____
Address: _____
City/State/Zip: _____

Release to and/or receive from: Name: _____
Sun Prairie Psychological Services

The specific purpose of this disclosure is:
_____ Continued patient care _____Transfer patient care
_____ Initial treatment planning _____ Other_____

Specific records authorized for release:
_____ Psychological testing _____Intake Summary
_____ Treatment Notes _____Discharge Summary
_____ Other_____

Dates of Treatment:_____

I understand that this authorization shall be valid for one year unless otherwise stated below or revoked through written notice.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that I have taken action in reliance of the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Your therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Alternate Date, if not one year_____

_____ _____
(Signature of individual who is subject to record) Date

_____ _____
(Signature of other who is legally authorized) Date