KARIS PSYCHOLOGICAL SERVICES

MARY NALLEN, PSY.D.

LICENCED CLINICAL PSYCHOLOGIST

Authorization to Release Protected Health Information (PHI)

I/We (*or the guardians for) _____/_____,
(patient's full name) (birth date)
hereby authorize Dr. Mary Nallen, Licensed Clinical Psychologist
To: _____ Release **to** and/or _____ Receive PHI **from**:

_____
(name)

_____
(address)

_____
(phone and fax)

Including the following ____ verbal and/or ____ written PHI:
_____ Summary of psychotherapy treatment
_____ Summary of psychiatric treatment
_____ School information/records/behavioral forms
_____ Psychological evaluation results/reports
_____ Medical history
_____ Other

For the purpose of:
_____ Continuity of care and treatment planning
_____ Third party reimbursement
_____ Legal proceedings
_____ Other

This consent is valid for six (6) months from the date of signature or until signing party revokes the authorization, if earlier than six months.

In signing this form, I understand the following:

a) I am under no obligation to sign
b) I have the right to inspect and copy an information disclosed
c) I have the right to revoke this authorization at anytime by written request
d) Failure to sign will mean information will not be requested or released

Signed_____ Signed_____
*Children ages 12-18 must consent to services

Witness_____ Date_____

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