Tristate Psychological Associates, PLLC

929 S. High St. #154, West Chester PA 19382

Authorization for Release of Confidential Information

I, ____, hereby authorize Tristate Psychological Associates, PLLC to:
Print name of Client or Representative

A) send to and/or B) receive from (Circle both if they apply)

____
Agency or Person

____ ____________________
Address of Agency or Person Phone of Agency or Person

written or verbal confidential and privileged information regarding:

________________________________ __________ __________
Client's Name Date of Birth

The following mental health information and/or records may be released:

____

and will be used for the purpose of:

____

I understand that: a) this information may be protected by federal, state or local law, and that I have no obligation to dis close this information; b) I may revoke this Authorization by notifying James Tscherne, **PsyD. in writing at any time, except to the ext ent that information has been released already in reliance hereon; c) this Authorization may be less restrictive than t he Consent already in effect; and d) I may receive a copy of this Authorization, and a copy of this Authorization will accompany the released information prov ided to the aforementioned person or agency. Having read or having had it explained to me, I understand fully the contents and purpose of this Authorization.**

_______________________________ / / ______ _______________________________ / / ______
Client or Representative Signature Date Witness Signature Date
My signature above also verifies that the Client received adequate explanation to make an informed decision

____
Description of Representative's Authority to Act for Client

This Authorization will expire on______/_____/_____, or one year after the date of execution, whichever comes first.
Date/Event

Verbal Authorization

The undersigned verify that verbal authorization for release of the above confidential information has been given. The dien t or parent/guardian was fully informed of the information contained herein and understood its nature and the intended use of the released information

_______________________ / / _______ _______________________ / /
Witness Signature Date Witness Signature Date

NOTICE TO RECIPIENT: The aforementioned information is disclosed to you from records whose confidentiality is protected by State and Federal statute. State and Federal regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

NOTICE TO CLIENT: The information hereby released may be subject to redisclosure by the recipient and may no longer be protected by the rule that requires this Authorization. In addition, Federal regulation prohibits further treatment being co nditioned on your signing this Authorization.

A mental health facility receiving a request for information from a governmental agency may accept that agency's Authorization t o Release Information form if it is signed by the client/parent/guardian responsible for the control of information, unless the cli ent/parent/guardian has specifically expressed opposition to that agency's receiving information.