Pacific Sunrise Psychological Services
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

Social Security Number: _____

I understand by signing this form, I am allowing Kristi L. Mueller, Psy.D. to disclose to and/or obtain information concerning the above named client from:

Name of Person or Institution: _____

Address: _____

Phone Number: _____ Fax Number: _____

Description of Information to be Disclosed:

- ☐ Pertinent treatment information
- ☐ Results of psychological assessment
- ☐ A copy of treatment records
- ☐ Other (Your description should be as specific and detailed as possible): _____

_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: _____

This authorization shall remain in effect until _____ or until _____.
(expiration date) (event)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that my psychologist 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. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date