Belinda A. Walker, Ph.D.
Licensed Psychologist

CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____/_____/_____

I, _____authorize Belinda A. Walker, Ph.D.
Client/Parent/Legal Guardian

To disclose and receive relevant information pertaining to the care and treatment of client from:

Contact person(s) and name of agency:_____

_____

Address:_____

Phone: _____ Fax: _____

I, the undersigned, understand that I may revoke this consent any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire sixty (60) days after the date of client discharge unless another date is specified.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 OFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose. **FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 OFR, PART 2 AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA).**

_____/_____/_____ _____
Date Signature of Client/Parent/Legal Guardian

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