Children's Psychological Services
www.childrenspsychologicalservices.com
Tel: 415-484-8479

Release of Information Form

Patient's Full/Legal Name: ______________ Date of Birth: _______________________

I, _________________________(your name), ____________________(relationship to patient), authorize Trishanjit K Singh, PsyD, of Children's Psychological Services to the use and disclosure of my child's confidential health information to:

Name of Person:______________________________ Organization: _____________________________________
Address: ____ Phone: _________________

Type of Authorization: (check all that apply): ___ Send and receive all records ___ Send records ___ Receive records

The purpose of this authorization: (check): ___ All ___ Assessment only ___ Therapy only

This authorization applies to the following confidential health information (check all that apply):

- __ All record
- __ Behavioral Reports/Observations
- __ Diagnosis, non-mental health related
- __ Diagnosis, mental health related
- __ Medical information, including test results and medications
- __ Occupational Therapy tests and treatment
- __ Speech/Language tests and treatment
- __ Psychological Tests and treatment
- __ Psychiatric History and treatment
- __ Educational tests and treatment
- __ Other: ___________________________

This authorization shall be valid until ____________. If no date is given, authorization is valid for five years from the parent/guardian signature date unless revoked earlier in writing, or when the client becomes 18 years of age.

I understand that this authorization is voluntary. I may revoke this authorization by providing a written or electronic notice (email) withdrawing my consent. Children's Psychological Services and many other organizations and individuals such as medical doctors, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment. The person signing this authorization has the right to receive a copy of this authorization form:

Parent/Guardian Signature: _________________________ Date: _____________________________

Printed Name: _____________________ Relationship to Patient:______________________________