

Sheila Sturgeon Freitas, Ph.D.
3709 N. Locust Grove Rd., Suite 150
Meridian, ID 83646
Phone: (208) 475-4690 Fax: (208) 899-4703
sheila@drsturgeonfreitas.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: _____

This form, when completed and signed by you, authorizes Dr. Sturgeon Freitas or her associates to release or obtain from an outside party, protected information from your records, from the records of your child or from the records of a person for whom you are legally responsible to the person/entity you designate.

I, _____, authorize _____ to:
_____ (send) _____ (receive) the following _____ (to) _____ (from)

Name: _____
Address: _____ City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

<input type="checkbox"/> Academic testing results	<input type="checkbox"/> Psychological testing results
<input type="checkbox"/> Behavior programs	<input type="checkbox"/> Service plans
<input type="checkbox"/> Progress reports	<input type="checkbox"/> Summary reports
<input type="checkbox"/> Intelligence testing results	<input type="checkbox"/> Vocational testing results
<input type="checkbox"/> Medical reports	<input type="checkbox"/> Entire record, except progress notes
<input type="checkbox"/> Personality profiles	<input type="checkbox"/> *Psychotherapy Notes
<input type="checkbox"/> Psychological reports	<input type="checkbox"/> Other, specify _____

The above information will be used for the following purposes:

Planning appropriate treatment or program
 Continuing appropriate treatment or program
 Determining eligibility for benefits or program
 Case review Updating files
 Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I also understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: Self Parent/legal guardian Personal representative
 Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, a description of such representative's authority to act for the patient must be provided.

Client's Signature: _____ Date: ____/____/____

Parent/guardian/personal representative (if applicable):

Signature: _____ Date: ____/____/____