Steven S. Minter, Th.M., Psy.D.

Clinical Psychology

Licensed Psychologist/PY 8553

AUTHORIZATION AND REQUEST FOR RELEASE OF CONFIDENTIAL PROTECTED HEALTH INFORMATION

In accordance with my legal right to confidentiality and privileged communication relevant to the professional services that I have received from Steven S. Minter, Th.M., Psy.D., I authorize him and/or his representatives to

- ❑ Release
- ❑ Obtain

my treatment information and clinical record

- ❑ To
- ❑ From

the following source(s): _____

_____

_____

_____

Note: Test data can only be released to a clinician qualified and credentialed to interpret such data. A treatment summary will be substituted for psychotherapy notes unless the actual notes are required by a court.

I issue this authorization with the knowledge of the contents of the material or communication so requested and an understanding of the consequences, and do so voluntarily and free from duress or undue influence. I agree to pay a reasonable fee, if any, for the preparation of the material and hereby hold harmless the above named practitioner from any liability relevant to the release of the confidential information or privileged communication.

This authorization expires on _____ unless revoked by me earlier in writing.

Name of Client: _____ Date of Birth: _____

Signature: _____ Date: _____

If this authorization is signed by someone other than the patient, except if the patient is a minor, a copy of the legal document of guardianship or power of attorney must be attached.

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