BRAIN METRICS

ASSESSMENT & PSYCHOLOGICAL SERVICES

Authorization for Release of Information

Patient Name: _____ Date: _____
Date of Birth: _____

I _____ [insert name of patient or guardian], hereby authorize Caitlin E. Ames, Psy.D., L.P. to disclose to and/or obtain from

Person/School/Organization/Entity: _____

Phone/Address: _____

any and all medical, psychological, and/or education information including reports, records, and/or documentation they possess regarding treatment, evaluation, and/or diagnosis. I understand that these records may contain information regarding educational, medical, psychiatric, and/or psychological treatment.

The information is to be disclosed for the purpose of (e.g. continuity of care, at request of patient, educational support, legal services):
_____

Exceptions and/or limitations to this release are as follows:
_____

Communication by telephone, cell phone, and email can be involved in administrative aspects of delivering assessment and psychological services. However, you should be aware that telephone, cell phone, and email are generally not considered a secure means of communication and should not be utilized in a clinical capacity.

☐ I consent to email communication ☐ I do not consent to email communication

This consent is subject to my revocation at any time, except to the extent action has been taken in reliance thereon. This consent expires one year from the date it is signed. I hereby release Caitlin E. Ames, Psy.D., L.P. from all legal responsibility or liability that may arise from the release of information and/or records. Treatment is not dependent upon my signing, except insofar as authorization may be obtained as a condition of obtaining insurance coverage or except insofar as protected health information (PHI) is necessary to assessment, report, or treatment contemplated by this authorization.

I understand that, once disclosed, the information may be subject to redisclosure by the recipient and may no longer be protected. The party obtaining this information is prohibited from further disclosure of this information unless specific written consent is obtained from the patient named above or the guardian of the patient named above. I have been provided a copy of this signed release.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

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