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Clinical Neuropsychology
Consulting

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Psychological Assessment
Psychotherapy

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize and request
(Client's Name)

_____ at _____
(Practitioner or School Name)

to release all pertinent confidential professional information pertaining to me (or my child) to

THE PURPOSE OF THIS RELEASE IS (check one or more)

- At the request of the patient/patient representative
 Other (state reason) _____

NOTICE

Scott Larson Ph.D. and many other organizations and individuals such as physicians, 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. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Scott Larson, Ph.D., 1151 Dove Street, Suite 240, Newport Beach, CA 92660. The revocation will take effect when Scott Larson, Ph.D. receives it, except to the extent that Scott Larson, Ph.D. or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

(Signature of Patient or Patient's Legal Representative)

Date: _____

Printed Name

Time: _____ AM / PM

(if signed by someone other than the patient, state your relationship to the patient/authority)

Witness (only if patient unable to sign) or Interpreter