

Beth Van Tassel, Ph.D., HSPP
Psychologist
10291 N. Meridian Street, Suite 160
Indianapolis IN 46290
317 853-1313 Fax 317 853-1314

Authorization for Release of Information

This form, when completed and signed, authorizes Dr. Beth Van Tassel to release and/or receive protected information to/from those designated below.

I, _____, date of birth _____, authorize Dr. Beth Van Tassel to do one or more of the following:

_____ to receive and/or furnish copies of all records and reports including but not limited to all medical and psychological or mental health records, including test results and raw test data if so requested, with the following person, agency or entity:

Name of person, agency or entity

Address and/or phone

_____ other: _____

This authorization of release of protected information is for the purpose of one of the following:

_____ treatment planning and coordination of mental health services

_____ other: _____

I understand that I have the right to revoke this authorization, in writing, by sending a written notification to this office at the above address, to the extent that this authorization has not been acted upon. I also understand that Dr. Van Tassel is not liable for any consequences of the disclosure by this office of the information authorized above. I give this consent voluntarily. If not previously revoked, this consent will terminate 365 days from the date of signing. I understand that information used or disclosed as a result of the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA Privacy Rule.

Signature of Patient/Guardian/ Parent

Date

Printed name of patient or Representative

Relationship of patient

Address of Above Signed