

_____ AUTHORIZATION TO RELEASE INFORMATION _____ AUTHORIZATION TO REQUEST INFORMATION _____ AUTHORIZATION TO EXCHANGE INFORMATION	Confidential Patient Information See California W.I.C. Section 5328 and/or Federal Reg. 42 CFR, Part 2
INFORMATION / RECORDS REQUESTED FROM: Name _____ Address _____ Phone _____ Fax _____	SEND / INFORMATION RECORDS TO: Kathline Colvin, Ph.D. 3419 Via Lido, Suite 173 Newport Beach, California 92663 (714) 593-6900 • Fax (714) 593-6955
Patient _____ DOB _____ SSN _____ Address _____ Phone _____	

Patient Initial: The following records and information may be released:

- _____ SCHOOL. School records consisting of transcripts, progress reports, behavioral reports, special incident reports, psychological testing, speech & language testing, and other information pertinent to the formulation of diagnostic impressions for the purpose of assisting in the clinical assessment and treatment of this patient.
- _____ PHYSICIAN. Medical records consisting of neurological/psychiatric evaluations, tests, treatments or consultations, lab reports, immunization records, history/physicals, medications, progress notes, and other information pertinent to the formulation of diagnostic impressions for the purpose of assisting in the clinical assessment and treatment of this patient.
- _____ MENTAL HEALTH PROFESSIONAL. Progress notes or summary, psychological testing, admission and discharge diagnoses, medications and responses, and other information pertinent to the formulation of diagnostic impressions for the purpose of assisting in the clinical assessment and treatment of this patient.
- _____ HOSPITAL OR OTHER CARE FACILITY. Admission and discharge summaries, quarterly reports, progress notes, psychological testing, psychiatric evaluations, behavioral reports, special incident reports, admission and discharge diagnoses, medications and responses, and other information pertinent to the formulation of diagnostic impressions for the purpose of assisting in the clinical assessment and treatment of this patient.
- _____ INSURANCE COMPANY. Diagnosis and treatment related information for the purpose of coordinating the authorization of and/or financial remuneration for psychological services rendered.
- _____ OTHER. _____

For the purpose of: _____

NOTE TO PATIENT. This authorization shall be limited to the Individual(s) and/or Organizations named above. Federal regulations (42 CFR Part 2) prohibit any further disclosure of the records without the specific written consent of the person to whom they pertain. However, Dr. Colvin has explained to me about the possibility of uncontrolled re-disclosure by other persons or parties.

Patient Initial:

- _____ I understand about the possibility of “uncontrolled re-disclosure” by other persons or organizations.
- _____ This authorization will expire after 2 years or when requested verbally or in writing, whichever is sooner.

 Patient / Parent or Legal Guardian

 Date

 Patient / Parent or Legal Guardian

 Date