

Wynns Family Psychology
1135 Kildaire Farm Rd., Suite 200
Cary, NC 27511

CONSENT TO RELEASE & EXCHANGE PATIENT INFORMATION

This form when completed and signed by you, authorizes Wynns Family Psychology to exchange protected information from your clinical record to the person you designate.

Patient Name _____ Birth Date _____

I authorize Wynns Family Psychology to exchange:

Psychological/Diagnostic Evaluation Educational Assessment School Records

Progress Update Medical History Developmental History

Other (specify): _____

This Information should only be exchanged with:

Name/Agency _____

Address _____

Phone _____

Purpose of Release: I am requesting my psychologist to exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

Continuity of Care Educational Other At the request of the individual

This authorization shall remain in effect until _____ (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

Signature of Parent/Guardian

Date

Relationship