Nationally Certified
School Psychologist

Pennsylvania Certified
Elementary Guidance Counselor

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Pennsylvania Licensed
Psychologist PS003431L

Pennsylvania Certified
School Psychologist

AUTHORIZATION TO RELEASE INFORMATION

I do hereby consent and authorize **MARGARET J. KAY, ED.D. PSYCHOLOGIST**, to use or disclose to:

Name: _____

Address: _____

Protected Health Information (PHI) from my record(s) related to my identity, diagnosis, prognosis and treatment (including diagnosis and/or treatment for mental health, drug/alcohol abuse and/or HIV-related information) for _____
Date of Birth: _____ The specific information to be used and disclosed includes:

_____History
_____Psychological Evaluation
_____Academic and Educational Records
_____Other (list specific items): _____
_____Progress Notes
_____Billing records
_____Complete copy of the medical record

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Public Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol treatment records), and/or Act 148 (Confidentiality of HIV-related Information Act). I understand the nature of this release and understand that I have the right to inspect material that is to be released. I understand that I may revoke this authorization at any time by notifying Margaret J. Kay, Psychologist.

This authorization shall be effective immediately and shall expire in one year from the date hereof or on _____ and is valid for all record documentation during the effective period.

I understand that I have the right to request a copy of this authorization and that I may revoke my consent at anytime by written notice.

_____ _____
Client's Signature (14 years or older) **Date**

_____ _____
Parent Signature (for clients 17 years or younger) **Date**

_____
Relationship to Client (completed when parent/guardian or person with Power of Attorney authorizes release for the client)

_____ _____
Signature of Witness **Date**

THIS PORTION TO BE COMPLETED WHEN CLIENT IS UNABLE TO GIVE WRITTEN CONSENT

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the above information. The client has also been informed that he/she may verbally revoke this authorization at any time.

_____ _____
Signature of Witness/Date **Signature of Witness/Date**

Diplomate, American Board of Psychological Specialties in Educational and School Psychology

2010