

AUTHORIZATION TO RELEASE INFORMATION

I do hereby consent and authorize **Independent Educational Evaluators of America, LLC** 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

Signature of Witness Date