



Heller Psychological Services, P.C.  
 Child/Adolescent/Adult Psychotherapy & Consulting  
 Lindsay Heller, Psy.D., Clinical Psychologist / PSY21400  
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**Request/Authorization to Release Confidential Records and Information**

Regarding (Name):

Social Security No.:

DOB:

Date:

This will authorize **Heller Psychological Services** to release/receive general medical, psychological/psychiatric information including alcohol/drug abuse or addiction from my health records in accordance with [CA] Statutes and [CA] and Federal Administrative Rules and Regulations to/from:

Information to be received is as follows:

- |   |   |
|---|---|
| <input type="checkbox"/> Histories and Physicals              | <input type="checkbox"/> Psychological Testing Raw Data |
| <input type="checkbox"/> Reports of Psychological Testing     | <input type="checkbox"/> Hospital Discharge Summary     |
| <input type="checkbox"/> Office Notes                         |   |
| <input type="checkbox"/> Other: Verbal treatment review _____ |   |

Purpose of Release:

- Continued Treatment  Other \_\_\_\_\_
- Psychological/Neuropsychological Evaluation
- At the request of the patient

Release Duration:

- One Time  Continuous for 90 days

I understand that I have the right to refuse to sign this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested. Consent is subject to revocation at any time except to the extent that the action based on this consent has already been taken. This authorization for release will automatically expire without further action 90 days after the date on which it was signed.

\_\_\_\_\_  
 [Signature]

\_\_\_\_\_  
 [Date]

\_\_\_\_\_  
 [Signature of Empowered Representative]

\_\_\_\_\_  
 [Witness] (If patient is unable to sign)