DR. LINDSAY HELLER
CLINICAL PSYCHOLOGIST

Heller Psychological Services, P.C.
Child/Adolescent/Adult Psychotherapy & Consulting
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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:

[ ] Histories and Physicals
[ ] Reports of Psychological Testing
[ ] Office Notes
[ ] Other: Verbal treatment review_____
[ ] Psychological Testing Raw Data
[ ] Hospital Discharge Summary

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)