SCW Psychological, Inc.

Authorization for Release of Information

Regarding the protected health information of: ____
Client Name

I authorize SCW Psychological, Inc., Dr. Suzanne Carroll Woodard, and/or administrative staff to

( ) Obtain and Release ( ) Obtain Only ( ) Release Only

the information identified below to/from:

(Name and contact information of person or organization)

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( ) Communication/Consultation ( ) Summary Reports ( ) Academic/Intelligence Testing Reports

( ) Entire Record ( ) Progress Notes ( ) Psychological Testing Results and Reports

( ) Lab Reports and Medical Record ( ) Other (specify)__________________________________

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment/Program ( ) Determining Eligibility for Benefits/Program

( ) Continuing Appropriate Treatment/Program ( ) Case Review ( ) Updating Files

( ) Other (specify)_________________________________

I understand that I may revoke this consent at any time by providing written notice which will be effective for all future protections of privacy. I understand that if I gave my provider previous permission to disclose information to an individual or organization that the revocation will be effective on the date signed above. I have been informed what information will be given, its purpose, and who will receive the information. I hereby release the above parties from all liability arising there from.

Signature of Patient ____ Date ______________

Signature of Parent/Guardian ____ Date ______________

Name of Child if under 18 ____

Relationship to child ( ) Parent ( ) Legal Guardian (specify) __________________________________