Kress Psychological Services, LLC
3021 E. 98th Street, Suite 180
Indianapolis, Indiana 46280
Telephone: 317-912-1500
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www.kresspsychology.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
Patient's Name Individual/School/Agency

_____ _____
Patient's Birthdate Patient Relation to Individual/School/Agency

_____ _____
Patient's Street Address Street Address of Individual/School/Agency

_____ _____
City, State, and Zip code City, State, and Zip code

_____
Telephone Number

I, _____, hereby authorize
Name of Legal Representative or Patient if 18 years or older
Kress Psychological Services, LLC to release and/or obtain with the Individual/School/Agency named above the following identified information concerning the patient named above:

____Initial Therapy Evaluation ____Psychiatric Evaluation ____School Behaviors/Performance

____ All Progress Notes ____Medication Records ____Educational Services Reports/Plan

____Psychological Testing ____Educational Evaluation ____Other:_____

The purpose of this disclosure is:

____Assessment & Treatment ____Coordination of Care ____Communication ____Other:_____

I understand that I may revoke this authorization in writing at any time, but the revocation will not apply to protected health information (PHI) already released from this Authorization. I understand that I am voluntarily signing this Authorization form and refusing to sign will not impact being able to receive treatment at Kress Psychological Services, LLC. I understand this Authorization will be valid for one hundred eighty (180) days. I understand that if I have questions about the use or disclosure of the PHI, I can contact Kress Psychological Services, LLC.

_____
Printed Name of Legal Representative or Patient (If 18 years or older)

_____ _____
Signature of Legal Representative or Patient (If 18 years or older) **Date**

_____
Relationship to Patient if Legal Representative

_____ _____
Witness **Date**